

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balta.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>310 Westshire Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HELEN DAVRY ADAMS</u>		4. DATE OF DEATH <u>June 10 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>School Teacher</u>	
11c. BIRTHPLACE (State or foreign country) <u>Troy N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Davry</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Brownee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John D. Adams</u>		Address <u>310 Westshire Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , to <u>June 10, 1959</u> , that I last saw the deceased alive on <u>June 7, 1959</u> , and that death occurred at <u>1 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1 Mallow Hill Ave., Baltimore 29, Md.</u> DATE SIGNED <u>6/10/59</u>			
ACTUAL SIGNATURE <u>Leo J. Caver</u> M.D.		PHYSICIAN'S NAME (Type) <u>Leo J. Caver, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation June 10-1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Gendel</u> ADDRESS <u>5311 Edmondson Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

IN FULL

<p>1. Name of deceased: <u>John V. Smith</u></p>	
<p>2. Date of death: <u>April 15, 1945</u></p>	
<p>3. Place of death: <u>Home</u></p>	
<p>4. Age at death: <u>68 years</u></p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Marital status: <u>Married</u></p>	
<p>8. Cause of death: <u>Heart disease</u></p>	
<p>9. Immediate cause: <u>Myocardial infarction</u></p>	
<p>10. Underlying cause: <u>Coronary artery disease</u></p>	
<p>11. Duration of illness: <u>Several days</u></p>	
<p>12. Name of attending physician: <u>Dr. J. H. Jones</u></p>	
<p>13. Name of medical examiner: <u>Dr. A. B. Brown</u></p>	
<p>14. Name of funeral home: <u>Smith &amp; Son</u></p>	
<p>15. Name of next of kin: <u>John V. Smith</u></p>	
<p>16. Name of informant: <u>John V. Smith</u></p>	
<p>17. Signature of medical examiner: <u>[Signature]</u></p>	
<p>18. Signature of attending physician: <u>[Signature]</u></p>	
<p>19. Date of filing: <u>April 16, 1945</u></p>	
<p>20. File number: <u>100-1-10000</u></p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6407 Item 2 R11 6-19-59 et CERTIFICATE OF DEATH

Reg. Dist. No. **06386**

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>City</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <span style="float: right;">3Y01-4</span>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5826 Jamview Avenue</u>				d. STREET ADDRESS <u>115 N. Clinton Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Mr. Joseph J. Adams</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>June 13th 19 59</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1884</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dredge Captain</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Owczarzak</u>				14. MOTHER'S MAIDEN NAME <u>Tina Zannenka</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>101-09-3172</u>		INFORMANT <u>Mrs. Elizabeth Kieffner</u> Address <u>same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>5-14-</u> , 19 <u>49</u> , to <u>6-1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-1</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <u>John J. Gould</u> M.D. <u>14 North East Avenue</u>				PHYSICIAN'S NAME (Type) <u>JOHN J. GOULD</u> <u>Baltimore, Maryland</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck 5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2. Page 2 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

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UNITED STATES DEPARTMENT OF JUSTICE

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 9, Film G244, 6/19/59 fcy									
6408 Item 2 Film G244 6-25-59 et									
Reg. Dist. No. 06387									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>1 yr. 6 mos.</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>New York City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville New York City</u> d. STREET ADDRESS <u>333 West 56th Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>D.</u> Last <u>Aikenhead</u>					4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1959</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 19 1886</u>		9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rochester N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James M. Aikenhead</u>					14. MOTHER'S MAIDEN NAME <u>Julia Felt</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		INFORMANT <u>Mrs. S. Zeller</u>		Address <u>College Manor</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Cerebral Thrombosis</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>diabetes mellitus</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 24 1958</u> to <u>6/12/59</u> that I last saw the deceased alive on <u>6/12</u> , 19 <u>59</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>William J. Felt</u>				M.D. <u>2 West University, Pkwy, Balto</u>		DATE SIGNED <u>6/12</u>			
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MOUNT HOPE</u>			22d. LOCATION (City, town, or county) (State) <u>ROCHESTER - NEW YORK</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM COCK-TOWSON - 1050 YORK RD</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>JUN 15 59</u>		24b. REGISTRAR'S SIGNATURE <u>George J. Kneass</u>	

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>lyrldy</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Mabel</b> Last <b>Anderson</b>				4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 7, 1899</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Maine</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Hanford</b> <del>Henry</del> <b>Curry</b>				14. MOTHER'S MAIDEN NAME <b>Nina (unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diffuse bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Purulent bronchitis</b> DUE TO (c) <b>week-plus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema of gall bladder. Diabetes mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 25, 1958</b> , to <b>6/27, 1959</b> , that I last saw the deceased alive on <b>6/27, 1959</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>6/27/59</b>							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b> Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>6/30/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickener &amp; Sons - Balto</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

252-11

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06389

6410

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Uppers - Rural</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>CLEVELAND - E - ARMACOST</u>			4. DATE OF DEATH <u>June 18</u> 19 <u>59</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 12 - 1885</u>		9. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Elijah Armacost</u>		
14. MOTHER'S MAIDEN NAME <u>Georgianne Armacost</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>NO</u>			17. INFORMANT Address <u>Mrs Elva Armacost - Uppers Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arterio-Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>5 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>June 2</u> , 19 <u>59</u> , to <u>June 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 18</u> , 19 <u>59</u> , and that death occurred at <u>3:30 p.m.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.			ADDRESS (Street, city or town, state) <u>28 So Main</u>		
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>			DATE SIGNED <u>6/19/59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 21-59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Grace Ave</u>	
22d. LOCATION (City, town, or county) <u>Balto so Md</u>		(State)		24a. REC'D BY REGISTRAR <u>JUN 22 '59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Epton, Hampstead Md</u>		ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinner</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6411

CERTIFICATE OF DEATH

06390

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>307 Greenwood Road #2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>G.</b> Last <b>ARNOLD</b>		4. DATE OF DEATH <b>June 4, 1959</b> Month <b>June</b> Day <b>4</b> Year <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1902</b>
9. AGE (In years lost birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min. <b>57</b>	IF UNDER 24 HRS. Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles J. Arnold</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Louisa Orrison</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>216-01-0911</b>		17. INFORMANT Address <b>Mrs. Mary L. Arnold-307 Greenwood Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Coronary artery Disease.</b> DUE TO (c) <b>arterio-sclerotic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>6 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 1, 1953</b> , to <b>June 4, 1959</b> , that I last saw the deceased alive on <b>June 3, 1959</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 E. Eager St., Baltimore, Md.</b> DATE SIGNED <b>June 4, 1959</b>			
ACTUAL SIGNATURE <b>Crawford N. Kirkpatrick, Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>CRAWFORD N. KIRKPATRICK, JR.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/6/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, I c. Towson 4, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06391

6400

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARBUTUS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Arbutus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1519 Vera AVE</u>		d. STREET ADDRESS <u>1 1519 Vera Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROSA</u> First <u>V</u> Middle <u>ARNOLD</u> Last		4. DATE OF DEATH Month <u>JUNE</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>unknown to inform</u>		14. MOTHER'S MAIDEN NAME <u>Arnold</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Charles Arnold - 1519 Vera Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heat exhaustion</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>260X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Diabetes - chronic heart failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>none</u>	
21. I certify that I attended the deceased from <u>1954</u> to <u>1959</u> , that I last saw the deceased alive on <u>10 June</u> , 19 <u>59</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Goodman</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1334 Sulfur Spring Rd</u> <u>Balt, 27, Md</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM GOODMAN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 15, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Ann Arundel Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. [unclear]</u>		ADDRESS <u>22247 [unclear]</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [unclear]</u>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06392

6412

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>72 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401.4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>4207 Groveland Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RUSSELL</u> Middle <u>Lee</u> Last <u>AVERY</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 9, 1899</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Structural Engineer(rtd) Engineering Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Honesdale, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>D. Leland Avery</u>				14. MOTHER'S MAIDEN NAME <u>A. Jennie Bishop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>071-09-0006</u>		17. INFORMANT <u>Clinical Records, VA Hosp., Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LAENNECS CIRRHOSIS</u> <u>581.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ESOPHAGEAL VARICES &amp; HEPATIC COMA</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that <u>VA</u> attended the deceased from <u>March 23, 1959</u> to <u>June 3, 1959</u> , that <u>he</u> was the deceased's <u>attending physician</u> , and that death occurred on <u>June 3, 1959</u> at <u>3:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Lawrence Fleisher</u>		M.D. <u>VA Hospital, Ft. Howard, Md.</u>		DATE SIGNED <u>6/3/59</u>			
PHYSICIAN'S NAME (Type) <u>T. LAWRENCE FLEISHER, M.D.</u>		<u>VA Hospital, Ft. Howard, Md.</u>		<u>6/3/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 5, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner &amp; Sons - Balto. 17th</u>				24a. REC'D BY REGISTRAR <u>BUN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

WM. J. TICKNER &amp; SONS, NORTH &amp; PENNA. AVES. BALTO. MD.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 6413 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>15yr4mth12dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Garland</u> Last <u>Bailey</u>		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 26, 1923</u>
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>scholar</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Garland Howard Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Harriett E. Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-32-1272</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hemorrhagic pancreatitis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>55</u> , to <u>June 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 9</u> , 19 <u>59</u> , and that death occurred at <u>4:45p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gertrude J. Fleischmann</u> M.D.		DATE SIGNED <u>6-9-59</u>	
PHYSICIAN'S NAME (Type) <u>GERTRUDE J. FLEISCHMANN</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 11, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Mausoleum</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell &amp; Sons Inc.</u>		ADDRESS <u>1900 Eutaw Place</u>	
24a. REC'D BY REGISTRAR <u>JUN 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Page 1 of 1

1. NAME OF DECEASED John C. (Spouse)		2. SEX Male		3. AGE 65	
4. DATE OF DEATH June 15, 1955		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN [Signature]	
10. SIGNATURE OF REGISTRAR [Signature]		11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF DECEASED [Signature]	
13. SIGNATURE OF NEXT OF KIN [Signature]		14. SIGNATURE OF BURIAL OFFICER [Signature]		15. SIGNATURE OF INTERMENT OFFICER [Signature]	
16. SIGNATURE OF FUNERAL HOME [Signature]		17. SIGNATURE OF CEMETERY [Signature]		18. SIGNATURE OF CHURCH [Signature]	
19. SIGNATURE OF MINISTRY [Signature]		20. SIGNATURE OF OTHER [Signature]		21. SIGNATURE OF OTHER [Signature]	
22. SIGNATURE OF OTHER [Signature]		23. SIGNATURE OF OTHER [Signature]		24. SIGNATURE OF OTHER [Signature]	
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97. SIGNATURE OF OTHER [Signature]		98. SIGNATURE OF OTHER [Signature]		99. SIGNATURE OF OTHER [Signature]	
100. SIGNATURE OF OTHER [Signature]		101. SIGNATURE OF OTHER [Signature]		102. SIGNATURE OF OTHER [Signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS ACT, CHAPTER 1-101, SECTION 1-101.01, AS AMENDED.

6401

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Halethorpe</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>801 Francis Ave.</u>		d. STREET ADDRESS <u>1801 Francis Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>George W. Baker</u>		4. DATE OF DEATH <u>June 21 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 17, 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Unknown (Deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Unknown (Deceased)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-26-4052</u>	
17. INFORMANT <u>Mazie Baker</u>		Address <u>801 Francis Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma left tonsil -</u> 145.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Inability to swallow - a slow</u> DUE TO (c) <u>dehydration -</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1957</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1953</u> , to <u>June 21 1959</u> , that I last saw the deceased alive on <u>June 20, 1959</u> , and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frederic V. Beidler</u>		ADDRESS (Street, city or town, state) <u>1014 Francis Ave - Balto 27 - Md</u>	
PHYSICIAN'S NAME (Type) <u>FREDERIC V. BEIDLER</u>		DATE SIGNED <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose, Inc 1328 Sulphur Spring Rd.</u>		24a. REC'D BY REGISTRAR <u>  </u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

10884

DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Page 2 of 2

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of medical examiner		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of hospital		17. Signature of nursing home		18. Signature of other institution	
19. Signature of other institution		20. Signature of other institution		21. Signature of other institution	
22. Signature of other institution		23. Signature of other institution		24. Signature of other institution	
25. Signature of other institution		26. Signature of other institution		27. Signature of other institution	
28. Signature of other institution		29. Signature of other institution		30. Signature of other institution	
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52. Signature of other institution		53. Signature of other institution		54. Signature of other institution	
55. Signature of other institution		56. Signature of other institution		57. Signature of other institution	
58. Signature of other institution		59. Signature of other institution		60. Signature of other institution	
61. Signature of other institution		62. Signature of other institution		63. Signature of other institution	
64. Signature of other institution		65. Signature of other institution		66. Signature of other institution	
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76. Signature of other institution		77. Signature of other institution		78. Signature of other institution	
79. Signature of other institution		80. Signature of other institution		81. Signature of other institution	
82. Signature of other institution		83. Signature of other institution		84. Signature of other institution	
85. Signature of other institution		86. Signature of other institution		87. Signature of other institution	
88. Signature of other institution		89. Signature of other institution		90. Signature of other institution	
91. Signature of other institution		92. Signature of other institution		93. Signature of other institution	
94. Signature of other institution		95. Signature of other institution		96. Signature of other institution	
97. Signature of other institution		98. Signature of other institution		99. Signature of other institution	
100. Signature of other institution		101. Signature of other institution		102. Signature of other institution	



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06395

## 6414 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN IB <b>7 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace, Maryland</b> 1224.2 ✓		d. STREET ADDRESS <b>609 Stokes Street -</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Janes</b> Last <b>Barnard</b>		4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 14, 1885</b> 73 yrs.
9. AGE (In years last birthday) <b>73</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Havre de Grace, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles J. Barnard</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Ellen Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 15</b> , 19 <b>59</b> , to <b>June 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 3</b> , 19 <b>59</b> , and that death occurred at <b>11040a</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-3-59</b>			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M. D. <b>SPRING GROVE STATE HOSPITAL 6-3-59</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/6/59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Havre de Grace Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kenna</b>		ADDRESS <b>Havre de Grace, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>1912</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Teacher</i>		RESIDENCE <i>123 Main St, Baltimore, Md</i>	
CAUSE OF DEATH <i>Heart Disease</i>		PLACE OF DEATH <i>Home</i>	
DATE OF BURIAL <i>1912</i>		PLACE OF BURIAL <i>Greenwood Cemetery</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>1912</i>		DATE OF SIGNATURE <i>1912</i>	

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THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06396

## 6415 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>21 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>FRANCIS</b> Last <b>BEAN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 29, 1912</b>	
9. AGE (In years last birthday) yrs. <b>46</b>		IF UNDER 1 YEAR Months <b>15</b> Days <b>x</b> Hours <b>2</b> Min. <b>2</b>		IF UNDER 24 HRS. Hours <b>15</b> Min. <b>x</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>		11. BIRTHPLACE (State or foreign country) <b>La Plata, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>William L. Bean</b>				14. MOTHER'S MAIDEN NAME <b>Emma F. Fitzsimmons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>217-05-8892</b>		17. INFORMANT Address <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, LEFT UPPER LOBE OF LUNG</b> <b>WITH METASTASIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 19, 1959</b> , to <b>June 9, 1959</b> , and that death occurred at <b>10:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6/10/59</b>							
ACTUAL SIGNATURE <b>W. J. Pijanowski</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>				PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-15-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner</b>				24a. REC'D BY REGISTRAR <b>JUN 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

TO HOSPITAL

may be retained

TO FUNERAL DIRECTOR:

page 3 should be detached for use at the burial-transit permit.

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ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

the hospital or attending physician.

After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the ren

Then please remove carbon papers. Pages 1 and 2 should be filed with the ren

death. Page 4

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 4&21 Film G243 6/17/59 cap

6416

## CERTIFICATE OF DEATH

06397

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 PROSPECT AVE.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> <span style="float: right;">b. COUNTY <u>BALTO.</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u> d. STREET ADDRESS <u>110 PROSPECT AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MICHAEL</u> Middle <u>BECCIO</u> Last <u>BECCIO</u>				<b>4. DATE OF DEATH</b> Month <u>JUNE</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 16, 1894</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR: Months <u>6</u> Days <u>4</u> Hours <u>10</u> Min. <u>19</u> IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthew Beccio</u>				14. MOTHER'S MAIDEN NAME <u>Alicienta Ercollini</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. Michael Beccio 110 Prospect Ave.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Carcinoma Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Artery Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>10, 1957</u>		
20f. (City or town) (County) (State)			20g. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>6/1/59</u> to <u>6/4/59</u> , that I last saw the deceased alive on <u>6/4</u> , 19 <u>59</u> , and that death occurred at <u>10:40</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Victor F. Zing</u> M.D. ADDRESS (Street, city or town, state) <u>Catonville, Md</u>				DATE SIGNED <u>6/5/59</u>			
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-8-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home - Catonsville, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

Register prior to burial, cremation, or removal, and in any event within 72 hours of death.

# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. PLACE OF BIRTH	
JAMES EARL RAY		Male		35		Memphis, Tennessee	
5. OCCUPATION		6. MARITAL STATUS		7. DATE OF DEATH		8. TIME OF DEATH	
Attorney		Single		April 4, 1968		4:00 PM	
9. CAUSE OF DEATH		10. MANNER OF DEATH		11. PLACE OF DEATH		12. SIGNATURE OF PHYSICIAN	
Suicide		Natural		Home		[Signature]	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED  
APR 10 1968  
BALTIMORE, MD



Butter 1/2 lb  
Eggs 2  
Milk 1/2 gal  
Sugar 1/2 lb  
Flour 1/2 lb  
Salt 1/2 lb  
Lard 1/2 lb  
Yeast 1/2 lb  
Cocoa 1/2 lb  
Vanilla 1/2 lb  
Almonds 1/2 lb  
Pistachios 1/2 lb  
Chestnuts 1/2 lb  
Raisins 1/2 lb  
Currants 1/2 lb  
Dried Fruit 1/2 lb  
Nuts 1/2 lb  
Spices 1/2 lb  
Essence 1/2 lb  
Coloring 1/2 lb  
Preservative 1/2 lb  
Sugar 1/2 lb  
Flour 1/2 lb  
Salt 1/2 lb  
Lard 1/2 lb  
Yeast 1/2 lb  
Cocoa 1/2 lb  
Vanilla 1/2 lb  
Almonds 1/2 lb  
Pistachios 1/2 lb  
Chestnuts 1/2 lb  
Raisins 1/2 lb  
Currants 1/2 lb  
Dried Fruit 1/2 lb  
Nuts 1/2 lb  
Spices 1/2 lb  
Essence 1/2 lb  
Coloring 1/2 lb  
Preservative 1/2 lb

Butter 1/2 lb  
Eggs 2  
Milk 1/2 gal  
Sugar 1/2 lb  
Flour 1/2 lb  
Salt 1/2 lb  
Lard 1/2 lb  
Yeast 1/2 lb  
Cocoa 1/2 lb  
Vanilla 1/2 lb  
Almonds 1/2 lb  
Pistachios 1/2 lb  
Chestnuts 1/2 lb  
Raisins 1/2 lb  
Currants 1/2 lb  
Dried Fruit 1/2 lb  
Nuts 1/2 lb  
Spices 1/2 lb  
Essence 1/2 lb  
Coloring 1/2 lb  
Preservative 1/2 lb  
Sugar 1/2 lb  
Flour 1/2 lb  
Salt 1/2 lb  
Lard 1/2 lb  
Yeast 1/2 lb  
Cocoa 1/2 lb  
Vanilla 1/2 lb  
Almonds 1/2 lb  
Pistachios 1/2 lb  
Chestnuts 1/2 lb  
Raisins 1/2 lb  
Currants 1/2 lb  
Dried Fruit 1/2 lb  
Nuts 1/2 lb  
Spices 1/2 lb  
Essence 1/2 lb  
Coloring 1/2 lb  
Preservative 1/2 lb

6418

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>35 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		<b>3Vo1-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2752 W. Mosher Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES</b>		First <b>A.</b>		Middle <b>BERRY</b>		Last	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <b>JUNE 24 19 59</b>	
9. AGE (In years last birthday) <b>79</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cleaner</b>		11. BIRTHPLACE (State or foreign country) <b>Jackson, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Berry</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hunter</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>3/8/01-3/7/04 225-28-2972</b>	
17. INFORMANT <b>Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, INTRA-ABDOMINAL</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____, 19____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>VA</b>		(County) <b>VA</b>		(State) <b>VA</b>	
21. I certify that _____ attended the deceased from _____, 19____, to _____, 19____, and that death occurred at _____, from the causes and on the date stated above.		22a. REC'D BY REGISTRAR DATE <b>JUN 30 '59</b>		22b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
22d. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22e. DATE THEREOF <b>6/29/59</b>		22f. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		22g. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips, Baltimore, Maryland</b>		23a. REC'D BY REGISTRAR DATE <b>JUN 30 '59</b>		23b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	

VS A15 (4)  
15M 10/57

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
 CERTIFICATE OF DEATH

Name of Deceased		John A. Howard	
Sex		Male	
Age		35 Years	
Date of Death		June 25, 1925	
Place of Death		Boston, Massachusetts	
Cause of Death		Typhoid Fever	
Occupation		Clerk	
Residence		123 North Street, Boston, Mass.	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		June 26, 1925	
Place of Registration		Boston, Massachusetts	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
 CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06401

## 6419 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>225 Sudbrook Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALVERTIE</b> Middle <b>BLANN</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 22, 1871</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. McMahon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>G. Raymond Blann</b>		Address <b>225 Sudbrook Ave., Pikesville 8 Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cholecystitis Acute</b> <b>584X</b> DUE TO <b>Cholelithiasis Chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS Generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Indef.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>14 June, 1959</b> to <b>16 June, 1959</b> , that I last saw the deceased alive on <b>16 June, 1959</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John V. DeWitt</b>		ADDRESS (Street, city or town, state) <b>Larch Haven Shopping Center</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Balto. Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickner</b>		24a. REC'D BY REGISTRAR <b>Jun 18 '59</b>	
ADDRESS <b>Sous - Balto. Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

# STATE OF NEW YORK DEPARTMENT OF HEALTH - BALTHAMOR, MD CERTIFICATE OF DEATH

Name of Deceased _____		Date of Death _____	
Age of Deceased _____		Sex of Deceased _____	
Usual Residence _____		Place of Death _____	
Cause of Death _____		Manner of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Signature _____		Date of Signature _____	



This certificate is to be filed in the office of the Registrar of the County of \_\_\_\_\_, State of New York, and a copy thereof to be sent to the office of the State Registrar of Vital Statistics, Albany, New York.

## 6420 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
c. LENGTH OF STAY IN 1b <b>67 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2590 W. Fayette Street (30)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WEBSTER</b>		First Middle Last <b>WEBSTER BLOXOM</b>		4. DATE OF DEATH Month Day Year <b>June 23 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>November 7, 1890</b>	9. AGE (In years last birthday) yrs. <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Henry Bloxom</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
14. MOTHER'S MAIDEN NAME <b>Sarah Adams</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>			
16. SOCIAL SECURITY NO. <b>220-01-1961</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, RIGHT LOWER LOBE</b> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 17</b> , 19 <b>59</b> , to <b>June 23</b> , 19 <b>59</b> , and that death occurred at <b>5:40 A.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>John W. Crawford</b>		ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		DATE SIGNED <b>6/23/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-26-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem. Baltimore, Maryland</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUN 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel W. Sullivan</b>		ADDRESS <b>1011 W. Arlington Ave. Baltimore Maryland</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



## 6421 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN IB <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR N. BOEMMEL</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14, 1920</b>
9. AGE (In years last birthday) <b>39</b> yrs.		10. UNDER 1 YEAR Months <b>13</b> Days <b>19</b> Hours <b>59</b>	11. UNDER 24 HRS. Months <b>13</b> Days <b>19</b> Hours <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Boemmel</b>		14. MOTHER'S MAIDEN NAME <b>Louise Rose</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>218-03-3807</b>	
17. INFORMANT <b>Clinical Rec. VA Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PANCREATITIS</b> <b>581.1</b> DUE TO <b>CIRRHOSIS, EARLY, ALCOHOLIC</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PERFORATION PSEUDO CYST OF PANCREAS</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12</b> , 19 <b>59</b> , to <b>June 13</b> , 19 <b>59</b> , and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Otto C. Reyer</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>6/14/59</b>	
PHYSICIAN'S NAME (Type) <b>OTTO C. REYER, M.D.</b>		VA Hospital, Ft. Howard, Md. <b>6/14/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/16/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>4430 Belair Rd., Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Orlinda S. Thomas</b>			

HENRY SANDER &amp; SONS, INC. NORTH AVE &amp; BROADWAY BALTO MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

## CERTIFICATE OF DEATH

NAME OF DECEASED _____	
SEX _____	
AGE _____	
DATE OF BIRTH _____	
PLACE OF BIRTH _____	
OCCUPATION _____	
CAUSE OF DEATH _____	
PLACE OF DEATH _____	
TIME OF DEATH _____	
SIGNATURE OF DECEASED _____	
SIGNATURE OF WITNESS _____	
SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF CLERK _____	

BALTIMORE  
 DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS  
 1910

6422

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 14</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 14</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1805 Berrywood Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Otto</u> Middle <u>Paul</u> Last <u>Boettger</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-21-1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Paul Boettger</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Hofman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	Address <u>Lillian Boettger</u> <u>Same</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>Diabetes, Paget's Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>?</u> <u>39 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 26</u> , 19 <u>59</u> , to <u>6. 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3. 28</u> , 19 <u>59</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		DATE SIGNED <u>JOSEPH SKLOVEN; M. D.</u> <u>7122 Harford Road</u> <u>Baltimore 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-6-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudin Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road</u>	24a. REC'D BY REGISTRAR DATE <u>JUN 5 '59</u>
			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6222



For Record

1907

Age

Sex

Color

Place

Birth

Death

Cause

Manner

Signature

Signature

Signature

Witness

Witness

Witness

Witness

Witness

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

6423 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Reisterstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Dover Rd.</b>		d. STREET ADDRESS <b>Dover Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MATILDA</b> First <b>M.</b> Middle <b>BREWER</b> Last		4. DATE OF DEATH <b>June 1, 1959</b> Month <b>June</b> Day <b>1</b> Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1874</b>
9. AGE (In years and birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>England</b>	
13. FATHER'S NAME <b>Richard Watson</b>		14. MOTHER'S MAIDEN NAME <b>Field</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Donald W. Brewer-Dover Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO <b></b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-59</b> to <b>6-1-59</b> , that I last saw the deceased alive on <b>5-15-59</b> and that death occurred at <b>11:30</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James G. Saffell</b> M.D.		ADDRESS (Street, city or town, state) <b>Reisterstown Md</b>	
PHYSICIAN'S NAME (Type) <b>James G. Saffell</b>		DATE SIGNED <b>6-1-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/4/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sater's Baptist</b>		22d. LOCATION (City, town, or county) (State) <b>Falls Rd. Balto. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc. Towson, Md.</b>		ADDRESS <b></b>	
24a. REC'D BY REGISTRAR <b>JUN 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Bowler</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
NAME OF PHYSICIAN [Illegible]		NAME OF FUNERAL HOME [Illegible]		NAME OF BURIAL PLACE [Illegible]	
NAME OF NEXT OF KIN [Illegible]		NAME OF WITNESS [Illegible]		NAME OF REGISTRAR [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF FUNERAL HOME [Illegible]		SIGNATURE OF BURIAL PLACE [Illegible]	
SIGNATURE OF NEXT OF KIN [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	

1

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT RECORDS AND STATISTICS.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6424 CERTIFICATE OF DEATH

06406

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>25yr 1mth 24dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Maryland</b>		1641-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>May</b> Middle <b>Hatch</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>separated</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>E. E. Hatch</b>		14. MOTHER'S MAIDEN NAME <b>Melvina Rowe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Bronchopneumonia</b> <b>422.1</b> DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 11</b> , 19 <b>59</b> , to <b>June 13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 13</b> , 19 <b>59</b> , and that death occurred at <b>5 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>James Donald Drinkard</b> M.D.		SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) <b>James Donald Drinkard, M.D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frederick Donaldson</b>		ADDRESS <b>313 Tellico ave</b>	
24a. REC'D BY REGISTRAR <b>JUN 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# STATE CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19

<p>NAME OF DECEASED</p>		<p>DATE OF DEATH</p>	
<p>AGE</p>		<p>SEX</p>	
<p>PLACE OF BIRTH</p>		<p>DATE OF BIRTH</p>	
<p>EDUCATION</p>		<p>OCCUPATION</p>	
<p>CAUSE OF DEATH</p>		<p>PLACE OF DEATH</p>	
<p>DATE OF INTERMENT</p>		<p>PLACE OF INTERMENT</p>	
<p>NAME OF FUNERAL HOME</p>		<p>NAME OF MINISTER</p>	
<p>NAME OF CLERGYMAN</p>		<p>NAME OF PHYSICIAN</p>	
<p>NAME OF SURGEON</p>		<p>NAME OF NURSE</p>	
<p>NAME OF ATTORNEY</p>		<p>NAME OF JUDGE</p>	
<p>NAME OF CLERK</p>		<p>NAME OF RECTOR</p>	
<p>NAME OF CHURCH</p>		<p>NAME OF CEMETERY</p>	
<p>NAME OF GRAVE</p>		<p>NAME OF MONUMENT</p>	
<p>NAME OF FUNERAL HOME</p>		<p>NAME OF MINISTER</p>	
<p>NAME OF CLERGYMAN</p>		<p>NAME OF PHYSICIAN</p>	
<p>NAME OF SURGEON</p>		<p>NAME OF NURSE</p>	
<p>NAME OF ATTORNEY</p>		<p>NAME OF JUDGE</p>	
<p>NAME OF CLERK</p>		<p>NAME OF RECTOR</p>	
<p>NAME OF CHURCH</p>		<p>NAME OF CEMETERY</p>	
<p>NAME OF GRAVE</p>		<p>NAME OF MONUMENT</p>	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF HIS OR HER DEATH. IT IS TO BE RETURNED TO THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF HIS OR HER DEATH. IT IS TO BE RETURNED TO THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF HIS OR HER DEATH.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06407

## 6425 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>35 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>M.</b> Last <b>BURKE</b>		4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 5, 1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Warehouseman</b>	
11. BIRTHPLACE (State or foreign country) <b>Myra, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James H. Burke</b>		14. MOTHER'S MAIDEN NAME <b>Virtreecy Newsome</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>220-05-1038</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA, CECUM, WITH GENERALIZED VISCERAL METASTASIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>153.0</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>April 28</b> , 1959, to <b>June 2</b> , 1959, and that death occurred at <b>9:45 A.M.</b> , from the causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE <b>Donald D. Mark</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>			DATE SIGNED <b>6/2/59</b>
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK</b> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-5-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Agington, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. K. No</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Travis</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by a hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

CASE

FILE NO.

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

AGE

SEX

EDUCATION

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

AGE

SEX

EDUCATION

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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CAUSE OF DEATH

AGE

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EDUCATION

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

AGE

SEX

EDUCATION

DATE OF BIRTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6426 CERTIFICATE OF DEATH

06408

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>6 wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Conv. Home</u>				e. STREET ADDRESS <u>'Cameron Mill Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary CAMERON</u>				4. DATE OF DEATH Month Day Year <u>June 1 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23 1883</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Royston</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Lowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>B. Frank Cameron, Parkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension Cardio Vascular disease</u> <u>443x</u> DUE TO <u>with left side hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , to <u>June 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>59</u> , and that death occurred at <u>10:45</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. France</u>				ADDRESS (Street, city or town, state) <u>Parkton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>				DATE SIGNED <u>6/2/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>				ADDRESS <u>New Freedom, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>							

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6427 CERTIFICATE OF DEATH

06409

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b <b>6mo. 1wk.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Howard</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS <b>13X-2</b>	
3. NAME OF DECEASED (Type or print) <b>Mittie</b>		First <b>Mittie</b>		Middle <b>Cardeir</b>		Last <b>Cardeir</b>		4. DATE OF DEATH Month <b>6</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/19/85</b>		9. AGE (In years last birthday) <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>W. Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <b>Gordon B. Carter</b>				14. MOTHER'S MAIDEN NAME <b>Sarah N. Bartz</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>For Advanced Pulmonary Tuberculosis</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>11/28, 1958</b> , to <b>6/6, 1959</b> , that I last saw the deceased alive on <b>6/6, 1959</b> , and that death occurred at <b>1 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____									
ACTUAL SIGNATURE <b>William Newcomer</b>		M.D. <b>Mt. Wilson, Maryland</b>							
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 9, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Longwood Cemetery</b>		22d. LOCATION (City, town, or county) <b>Longwood, Florida</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters</b>		ADDRESS <b>254 Carroll St NW</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06410

## 6428 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shady Nook Nursing Home</u>		d. STREET ADDRESS <u>4430 Marble Hall Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>S.</u> Last <u>CATLING</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 4, 1869</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Shaw</u>		14. MOTHER'S MAIDEN NAME <u>Mary Barnum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mr. Edward Catling - 4224 Loch Raven</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 wks.</u> <u>12-17</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-12-1958</u> to <u>6-13-1959</u> , that I last saw the deceased alive on <u>June 13, 1959</u> , and that death occurred at <u>11:25</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> M.D.		ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED <u>6-15-59</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		<u>Baltimore-28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner &amp; Sons - Balto</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 15 '59</u>	
ADDRESS <u>17 Mid</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

6391

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12,</b>				c. LENGTH OF STAY IN 1b <b>15 yrs.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Baltimore 12,</b>				d. STREET ADDRESS <b>6408 Blenheim Rd.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6408 Blenheim Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Donaldson</b> Middle <b>Cleveland</b> Last				4. DATE OF DEATH Month <b>6-16-59</b> Day Year <b>19</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-4-<del>38</del> 1900</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>investment broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>investment</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John S. Cleveland</b>				14. MOTHER'S MAIDEN NAME <b>Edna Wagner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-03-0923</b>		17. INFORMANT <b>Mrs. Eleanor Cleveland</b>		Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung, primary (broncho- 162.1</b> DUE TO genic), with metastasis.						INTERVAL BETWEEN ONSET AND DEATH <b>1st visit 9/3/58</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>no accident or injury</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/3/58</b> , 19____, to <b>6/17/59</b> , 19____, that I last saw the deceased alive on <b>6/17/59</b> , 19____, and that death occurred at <b>2 a.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1205 N. Calvert St., Baltimore 2, Md.</b> DATE SIGNED <b>6/17/59</b>							
ACTUAL SIGNATURE <b>Hugh J. Welch, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Hugh J. Welch, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-18-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. James Episcopal</b>		22d. LOCATION (City, town, or county) (State) <b>Monkton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, 622 York Rd.</b>				24. REC'D BY REGISTRAR DATE <b>JUN 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6429

CERTIFICATE OF DEATH

06413

Reg. Dist. No.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1408 Ingleside Ave</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>1408 Ingleside Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Catherine R. Cochran</u> First Middle Last 4. DATE OF DEATH <u>6/12</u> Month Day Year <u>1959</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6 10 1899</u> 9. AGE (In years last birthday) <u>60</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker at home</u> 11. BIRTHPLACE (State or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Joseph Jacobs</u> 14. MOTHER'S MAIDEN NAME <u>Catherine Boyer</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <u>Leonard Cochran</u> INFORMANT Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>ASHD</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive CVD</u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate death</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>3/1</u> , 19 <u>59</u> , to <u>6/12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/6</u> , 19 <u>59</u> , and that death occurred at <u>1 A.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Max J. Miller</u> M.D. ADDRESS (Street, city or town, state) <u>8047 Ingleside Ave</u> DATE SIGNED <u>6/13/59</u> PHYSICIAN'S NAME (Type) <u>MAX J. Miller M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/16/59</u>		<u>Balto. National</u>		<u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



## 6430 CERTIFICATE OF DEATH

06414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3 Y 01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>House in Pines</u>		d. STREET ADDRESS <u>3624 Park Heights Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>R.</u> Last <u>Cohen</u>		4. DATE OF DEATH Month <u>6-</u> Day <u>19-</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Romania</u>
13. FATHER'S NAME <u>Louis</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Monroe Katz - same</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Acute Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 year</u> <u>10 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 1955</u> to <u>June 19, 1959</u> that I last saw the deceased alive on <u>June 19, 1959</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Rudnor</u> M.D.		ADDRESS (Street, city or town, state) <u>6821 Kinston Road, Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>CCCIC</u>		DATE SIGNED <u>6/20/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beth Isaac</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eastward Place</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

1

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

11200

CERTIFICATE OF DEATH

CASE

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

1

6392

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sundair</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1000 Fairfaxway</u>		e. STREET ADDRESS <u>SPARROWS POINT-19</u> <u>RED BOX 375</u>	
3. NAME OF DECEASED (Type or print) <u>Lewis Corbin Cole, Sr.</u>		4. DATE OF DEATH <u>JUNE 10 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 25, 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR <u>5</u> Months <u>10</u> Days <u>—</u> Hours <u>—</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Essex, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Addison Cole</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Corbin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-20-5711</u>	
17. INFORMANT <u>Robert L. Cole, Sr.</u>		Address <u>8013 Morris Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>URÆMIA</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>NEPHRITIS</u> (c) <u>ARTERIO SCLEROSIS, Generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>14R</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 2, 1956</u> , to <u>JUNE 19, 1959</u> , that I last saw the deceased alive on <u>JUNE 10, 1959</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Wade</u>		ADDRESS (Street, city or town, state) <u>140 Oak Ave, Dundalk, Md.</u> DATE SIGNED <u>6-10-59</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-14-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus mem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ethel O. Wilson</u> ADDRESS <u>1000 Brantley Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 11 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

6393

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>10-15-1961</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF INTERMENT <i>St. John's Cemetery</i>	
10. SIGNATURE OF DECEASED <i>John A. Smith</i>		11. SIGNATURE OF WITNESSES <i>John A. Smith</i>		12. SIGNATURE OF DECEASED <i>John A. Smith</i>	
13. SIGNATURE OF DECEASED <i>John A. Smith</i>		14. SIGNATURE OF DECEASED <i>John A. Smith</i>		15. SIGNATURE OF DECEASED <i>John A. Smith</i>	
16. SIGNATURE OF DECEASED <i>John A. Smith</i>		17. SIGNATURE OF DECEASED <i>John A. Smith</i>		18. SIGNATURE OF DECEASED <i>John A. Smith</i>	
19. SIGNATURE OF DECEASED <i>John A. Smith</i>		20. SIGNATURE OF DECEASED <i>John A. Smith</i>		21. SIGNATURE OF DECEASED <i>John A. Smith</i>	
22. SIGNATURE OF DECEASED <i>John A. Smith</i>		23. SIGNATURE OF DECEASED <i>John A. Smith</i>		24. SIGNATURE OF DECEASED <i>John A. Smith</i>	
25. SIGNATURE OF DECEASED <i>John A. Smith</i>		26. SIGNATURE OF DECEASED <i>John A. Smith</i>		27. SIGNATURE OF DECEASED <i>John A. Smith</i>	
28. SIGNATURE OF DECEASED <i>John A. Smith</i>		29. SIGNATURE OF DECEASED <i>John A. Smith</i>		30. SIGNATURE OF DECEASED <i>John A. Smith</i>	
31. SIGNATURE OF DECEASED <i>John A. Smith</i>		32. SIGNATURE OF DECEASED <i>John A. Smith</i>		33. SIGNATURE OF DECEASED <i>John A. Smith</i>	
34. SIGNATURE OF DECEASED <i>John A. Smith</i>		35. SIGNATURE OF DECEASED <i>John A. Smith</i>		36. SIGNATURE OF DECEASED <i>John A. Smith</i>	
37. SIGNATURE OF DECEASED <i>John A. Smith</i>		38. SIGNATURE OF DECEASED <i>John A. Smith</i>		39. SIGNATURE OF DECEASED <i>John A. Smith</i>	
40. SIGNATURE OF DECEASED <i>John A. Smith</i>		41. SIGNATURE OF DECEASED <i>John A. Smith</i>		42. SIGNATURE OF DECEASED <i>John A. Smith</i>	
43. SIGNATURE OF DECEASED <i>John A. Smith</i>		44. SIGNATURE OF DECEASED <i>John A. Smith</i>		45. SIGNATURE OF DECEASED <i>John A. Smith</i>	
46. SIGNATURE OF DECEASED <i>John A. Smith</i>		47. SIGNATURE OF DECEASED <i>John A. Smith</i>		48. SIGNATURE OF DECEASED <i>John A. Smith</i>	
49. SIGNATURE OF DECEASED <i>John A. Smith</i>		50. SIGNATURE OF DECEASED <i>John A. Smith</i>		51. SIGNATURE OF DECEASED <i>John A. Smith</i>	
52. SIGNATURE OF DECEASED <i>John A. Smith</i>		53. SIGNATURE OF DECEASED <i>John A. Smith</i>		54. SIGNATURE OF DECEASED <i>John A. Smith</i>	
55. SIGNATURE OF DECEASED <i>John A. Smith</i>		56. SIGNATURE OF DECEASED <i>John A. Smith</i>		57. SIGNATURE OF DECEASED <i>John A. Smith</i>	
58. SIGNATURE OF DECEASED <i>John A. Smith</i>		59. SIGNATURE OF DECEASED <i>John A. Smith</i>		60. SIGNATURE OF DECEASED <i>John A. Smith</i>	
61. SIGNATURE OF DECEASED <i>John A. Smith</i>		62. SIGNATURE OF DECEASED <i>John A. Smith</i>		63. SIGNATURE OF DECEASED <i>John A. Smith</i>	
64. SIGNATURE OF DECEASED <i>John A. Smith</i>		65. SIGNATURE OF DECEASED <i>John A. Smith</i>		66. SIGNATURE OF DECEASED <i>John A. Smith</i>	
67. SIGNATURE OF DECEASED <i>John A. Smith</i>		68. SIGNATURE OF DECEASED <i>John A. Smith</i>		69. SIGNATURE OF DECEASED <i>John A. Smith</i>	
70. SIGNATURE OF DECEASED <i>John A. Smith</i>		71. SIGNATURE OF DECEASED <i>John A. Smith</i>		72. SIGNATURE OF DECEASED <i>John A. Smith</i>	
73. SIGNATURE OF DECEASED <i>John A. Smith</i>		74. SIGNATURE OF DECEASED <i>John A. Smith</i>		75. SIGNATURE OF DECEASED <i>John A. Smith</i>	
76. SIGNATURE OF DECEASED <i>John A. Smith</i>		77. SIGNATURE OF DECEASED <i>John A. Smith</i>		78. SIGNATURE OF DECEASED <i>John A. Smith</i>	
79. SIGNATURE OF DECEASED <i>John A. Smith</i>		80. SIGNATURE OF DECEASED <i>John A. Smith</i>		81. SIGNATURE OF DECEASED <i>John A. Smith</i>	
82. SIGNATURE OF DECEASED <i>John A. Smith</i>		83. SIGNATURE OF DECEASED <i>John A. Smith</i>		84. SIGNATURE OF DECEASED <i>John A. Smith</i>	
85. SIGNATURE OF DECEASED <i>John A. Smith</i>		86. SIGNATURE OF DECEASED <i>John A. Smith</i>		87. SIGNATURE OF DECEASED <i>John A. Smith</i>	
88. SIGNATURE OF DECEASED <i>John A. Smith</i>		89. SIGNATURE OF DECEASED <i>John A. Smith</i>		90. SIGNATURE OF DECEASED <i>John A. Smith</i>	
91. SIGNATURE OF DECEASED <i>John A. Smith</i>		92. SIGNATURE OF DECEASED <i>John A. Smith</i>		93. SIGNATURE OF DECEASED <i>John A. Smith</i>	
94. SIGNATURE OF DECEASED <i>John A. Smith</i>		95. SIGNATURE OF DECEASED <i>John A. Smith</i>		96. SIGNATURE OF DECEASED <i>John A. Smith</i>	
97. SIGNATURE OF DECEASED <i>John A. Smith</i>		98. SIGNATURE OF DECEASED <i>John A. Smith</i>		99. SIGNATURE OF DECEASED <i>John A. Smith</i>	
100. SIGNATURE OF DECEASED <i>John A. Smith</i>		101. SIGNATURE OF DECEASED <i>John A. Smith</i>		102. SIGNATURE OF DECEASED <i>John A. Smith</i>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. IT IS NOT VALID FOR ANY OTHER PURPOSES.

## 6431 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>3 Vol-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>133 Slade Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Reba</u> First <u>Cole</u> Middle Last		4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington DC</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman Herbert</u>		14. MOTHER'S MAIDEN NAME <u>Betty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>5023 Cambridge Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of uterus</u> DUE TO (b) <u>none</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>none</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 8</u> , 19 <u>57</u> , to <u>June 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 30</u> , 19 <u>59</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Manuel Levin</u>		ADDRESS (Street, city or town, state) <u>4818 Reisterstown Road</u> DATE SIGNED <u>6/30/59</u>	
PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN, M.D.</u>		<u>BALTIMORE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7-1-59</u>	22c. NAME OF CEMETERY OR CREMATOR <u>Herring Run</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Levine</u> ADDRESS <u>2100 Eutan Place</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 6432 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson #4</i>		c. LENGTH OF STAY IN 1b <i>55</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8427 Loch Raven Blvd</i>		d. STREET ADDRESS <i>8427 Loch Raven Blvd</i>	
3. NAME OF DECEASED (Type or print) <i>HOWARD L CRISE SR.</i>		4. DATE OF DEATH <i>June 27 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-11-1886</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR: Months <i>72</i> Days <i>72</i> Hours <i>72</i> Min. <i>72</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Realtor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John L Crise</i>		14. MOTHER'S MAIDEN NAME <i>Melinda Raborg</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Howard L Crise</i>	
17. INFORMANT <i>Howard L Crise</i>		Address <i>8419 Loch Raven Blvd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Artery disease</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>~3 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 19, 1955</i> to <i>June 27, 1959</i> , that I last saw the deceased alive on <i>June 22, 1959</i> , and that death occurred at <i>6:00 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Richard Rigler</i>		M.D. <i>I W Overlea Ave Balto 6</i>	
PHYSICIAN'S NAME (Type) <i>Richard Rigler</i>		ADDRESS (Street, city or town, state) <i>I W Overlea Ave Balto. 6 Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 29/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Green Mount</i>		22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W Jenkins &amp; Son</i>		ADDRESS <i>4905 York Rd</i>	
24a. REC'D BY REGISTRAR <i>DATE JUN 30 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6393

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> MARYLAND <i>126 Honeysuckle Ct.</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Turner Station</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>126 Honeysuckle Ct.</i>				d. STREET ADDRESS <i>126 Honeysuckle Ct.</i>			
3. NAME OF DECEASED (Type or print) First <i>Geneva</i> Middle <i>C</i> Last <i>Curry</i>				4. DATE OF DEATH Month <i>June</i> Day <i>9</i> Year <i>1959</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 30, 1899</i>	
9. AGE (In years last birthday) yrs. <i>60</i>		IF UNDER 1 YEAR Months <i>6</i> Days <i>10</i> Hours <i>15</i> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <i>Sanitress</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Cristfield Md.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Hattie?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wilson E. Curry</i> Address <i>126 Honeysuckle Ct.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i> DUE TO <i>196.7</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>metastatic sarcoma of ribs, spine lungs</i> DUE TO <i>3 mo</i> (c) <i>Sarcoma of right femur</i> <i>6 mo</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <i>20 min.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec. 3</i> , 1958, to <i>June 9</i> , 1959, that I last saw the deceased alive on <i>June 9</i> , 1959, and that death occurred at <i>10:40 P.</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R. W. McDaniel</i>				ADDRESS (Street, city or town, state) <i>1500 E. Madison St</i> DATE SIGNED <i>Balto. 5, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/13/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Carver Mem. Park</i>		22d. LOCATION (City, town, or county) (State) <i>Laurel Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank T. Elickson</i>				ADDRESS <i>11297. Cudwin St</i>		24a. REC'D BY REGISTRAR DATE <i>6/11/59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6593

PLACE OF BIRTH		MARRIAGE	
A. CITY OR TOWN OF BIRTH		B. DATE OF MARRIAGE	
C. STATE OF BIRTH		D. DATE OF MARRIAGE	
E. NAME OF DECEASED		F. SEX	
G. AGE		H. OCCUPATION	
I. DATE OF DEATH		J. TIME OF DEATH	
K. PLACE OF DEATH		L. CAUSE OF DEATH	
M. MEDICAL HISTORY		N. HISTORY OF PRESENT ILLNESS	
O. HISTORY OF PRESENT ILLNESS		P. HISTORY OF PRESENT ILLNESS	
Q. HISTORY OF PRESENT ILLNESS		R. HISTORY OF PRESENT ILLNESS	
S. HISTORY OF PRESENT ILLNESS		T. HISTORY OF PRESENT ILLNESS	
U. HISTORY OF PRESENT ILLNESS		V. HISTORY OF PRESENT ILLNESS	
W. HISTORY OF PRESENT ILLNESS		X. HISTORY OF PRESENT ILLNESS	
Y. HISTORY OF PRESENT ILLNESS		Z. HISTORY OF PRESENT ILLNESS	
AA. HISTORY OF PRESENT ILLNESS		AB. HISTORY OF PRESENT ILLNESS	
AC. HISTORY OF PRESENT ILLNESS		AD. HISTORY OF PRESENT ILLNESS	
AE. HISTORY OF PRESENT ILLNESS		AF. HISTORY OF PRESENT ILLNESS	
AG. HISTORY OF PRESENT ILLNESS		AH. HISTORY OF PRESENT ILLNESS	
AI. HISTORY OF PRESENT ILLNESS		AJ. HISTORY OF PRESENT ILLNESS	
AK. HISTORY OF PRESENT ILLNESS		AL. HISTORY OF PRESENT ILLNESS	
AM. HISTORY OF PRESENT ILLNESS		AN. HISTORY OF PRESENT ILLNESS	
AO. HISTORY OF PRESENT ILLNESS		AP. HISTORY OF PRESENT ILLNESS	
AQ. HISTORY OF PRESENT ILLNESS		AR. HISTORY OF PRESENT ILLNESS	
AS. HISTORY OF PRESENT ILLNESS		AT. HISTORY OF PRESENT ILLNESS	
AU. HISTORY OF PRESENT ILLNESS		AV. HISTORY OF PRESENT ILLNESS	
AW. HISTORY OF PRESENT ILLNESS		AX. HISTORY OF PRESENT ILLNESS	
AY. HISTORY OF PRESENT ILLNESS		AZ. HISTORY OF PRESENT ILLNESS	
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BC. HISTORY OF PRESENT ILLNESS		BD. HISTORY OF PRESENT ILLNESS	
BE. HISTORY OF PRESENT ILLNESS		BF. HISTORY OF PRESENT ILLNESS	
BG. HISTORY OF PRESENT ILLNESS		BH. HISTORY OF PRESENT ILLNESS	
BI. HISTORY OF PRESENT ILLNESS		BJ. HISTORY OF PRESENT ILLNESS	
BK. HISTORY OF PRESENT ILLNESS		BL. HISTORY OF PRESENT ILLNESS	
BM. HISTORY OF PRESENT ILLNESS		BN. HISTORY OF PRESENT ILLNESS	
BO. HISTORY OF PRESENT ILLNESS		BP. HISTORY OF PRESENT ILLNESS	
BQ. HISTORY OF PRESENT ILLNESS		BR. HISTORY OF PRESENT ILLNESS	
BS. HISTORY OF PRESENT ILLNESS		BT. HISTORY OF PRESENT ILLNESS	
BU. HISTORY OF PRESENT ILLNESS		BV. HISTORY OF PRESENT ILLNESS	
BW. HISTORY OF PRESENT ILLNESS		BX. HISTORY OF PRESENT ILLNESS	
BY. HISTORY OF PRESENT ILLNESS		BZ. HISTORY OF PRESENT ILLNESS	
CA. HISTORY OF PRESENT ILLNESS		CB. HISTORY OF PRESENT ILLNESS	
CC. HISTORY OF PRESENT ILLNESS		CD. HISTORY OF PRESENT ILLNESS	
CE. HISTORY OF PRESENT ILLNESS		CF. HISTORY OF PRESENT ILLNESS	
CG. HISTORY OF PRESENT ILLNESS		CH. HISTORY OF PRESENT ILLNESS	
CI. HISTORY OF PRESENT ILLNESS		CJ. HISTORY OF PRESENT ILLNESS	
CK. HISTORY OF PRESENT ILLNESS		CL. HISTORY OF PRESENT ILLNESS	
CM. HISTORY OF PRESENT ILLNESS		CN. HISTORY OF PRESENT ILLNESS	
CO. HISTORY OF PRESENT ILLNESS		CP. HISTORY OF PRESENT ILLNESS	
CQ. HISTORY OF PRESENT ILLNESS		CR. HISTORY OF PRESENT ILLNESS	
CS. HISTORY OF PRESENT ILLNESS		CT. HISTORY OF PRESENT ILLNESS	
CU. HISTORY OF PRESENT ILLNESS		CV. HISTORY OF PRESENT ILLNESS	
CW. HISTORY OF PRESENT ILLNESS		CX. HISTORY OF PRESENT ILLNESS	
CY. HISTORY OF PRESENT ILLNESS		CZ. HISTORY OF PRESENT ILLNESS	
DA. HISTORY OF PRESENT ILLNESS		DB. HISTORY OF PRESENT ILLNESS	
DC. HISTORY OF PRESENT ILLNESS		DD. HISTORY OF PRESENT ILLNESS	
DE. HISTORY OF PRESENT ILLNESS		DE. HISTORY OF PRESENT ILLNESS	

1

As required by law, the death certificate must be filed with the local health officer within 24 hours of the death. The local health officer will forward the certificate to the State Department of Health. The certificate is a legal document and must be filled out accurately. The information on the certificate is used for statistical purposes and to determine the cause of death. The certificate is also used to determine the eligibility for certain benefits. The certificate is a permanent record of the death and is used for many purposes. The certificate is a legal document and must be filled out accurately. The information on the certificate is used for statistical purposes and to determine the cause of death. The certificate is also used to determine the eligibility for certain benefits. The certificate is a permanent record of the death and is used for many purposes.

6/1/54  
Baltimore, Md.

6433

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN lb <u>80 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FOREST HAVEN NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>DAVIS</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 14-1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>HUNGARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>MARVIN DAVIS - 2880 Woodbrook Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>ARTERIAL SCLEROTIC CIRCULATORY COLLAPSE</u> DISEASE (b) <u>DIAbetes mellitus</u> DUE TO (c) <u>MYOCARDIAL CIRCULATORY COLLAPSE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/22</u> , 19 <u>59</u> , to <u>6/22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/22</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>6/23/59</u>			
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PHYSICIAN'S NAME (Type) <u>John H. Shaw MD BALTO 2880</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-24-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HEBREW FRIENDSHIP</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Lewis</u> ADDRESS <u>2100 Eulaw Place</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 24 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finney</u>	

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6633 - CENTRAL OF SPAIN

RECEIVED  
JAN 10 1964  
U.S. DEPT. OF HEALTH  
DIVISION OF INTERNATIONAL  
RELATIONS

1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06420

## 6434 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>26 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWIN</b> Middle <b>L.</b> Last <b>DAY</b>		4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 19, 1912</b>
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min.	IF UNDER 24 HRS. Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Day</b>		14. MOTHER'S MAIDEN NAME <b>Marie MN: Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>WW II</b>	
17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>APICAL MYOCARDIAL INFARCT</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <b>SEVERE CORONARY ARTERIOSCLEROSIS WITH OCCLUSION, LEFT ANTERIOR DESCENDING BRANCH</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>26 DAYS</b> <b>UNKNOWN</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>VA</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 14</b> , 19 <b>59</b> , to <b>June 9</b> , 19 <b>59</b> , and that death occurred at <b>9:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6/10/59</b>			
ACTUAL SIGNATURE <b>W. W. Schier</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>W. W. SCHIER, M.D., Director, Professional Services, VAH, Fort Howard, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward S. McNabb Funeral Home, Frederick &amp; Wade</b>		24a. REC'D BY REGISTRAR <b>Aves.</b> DATE <b>JUN 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11-5-11

DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		11-5-11	
Age		Sex	
65		Male	
Race		Marital Status	
White		Married	
Place of Birth		Usual Residence	
New York, N.Y.		123 Main St, Baltimore, Md.	
Cause of Death		Immediate Cause	
Myocardial Infarction		Coronary Atherosclerosis	
Duration of Illness		Time of Death	
2 Weeks		11:00 AM	
Place of Death		Physician's Signature	
Home		[Signature]	
Attending Physician		Medical Examiner's Signature	
Dr. Smith		[Signature]	
Hospital		Burial or Disposition	
None		Buried in [Cemetery Name]	
Funeral Home		Date of Burial	
None		11-10-11	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Perry Hall</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Perry Hall</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Old Phila. Rd. Box 344</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Bessie M.</i> Middle <i>DeBaugh</i> Last				4. DATE OF DEATH Month <i>June</i> Day <i>16</i> Year <i>1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 31, 1891</i>	9. AGE (In years last birthday) <i>68</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Hecker</i>				14. MOTHER'S MAIDEN NAME <i>Linker</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			16. SOCIAL SECURITY NO.		INFORMANT <i>Joseph C. DeBaugh</i> Address <i>same</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.1</i> DUE TO <i>Congestive Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>General Arteriosclerosis</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>4 mos. 15 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic Degeneration of Feet</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6/15</i> to <i>6/16</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>6/15</i> , 19 <i>59</i> , and that death occurred at <i>12:30 PM</i> , from the causes and on the date stated above. <i>Clifford F. Hudson</i> ADDRESS (Street, city or town, state) <i>FORK MD.</i> DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <i>CLIFFORD F. HUDSON FORK, MD.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/19/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 18 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Carroll A. [illegible]</i>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10451

CERTIFICATE OF DEATH

8-33

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6436

CERTIFICATE OF DEATH

06305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>Baltimore</b> <b>3001-4</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home-301 Chesapeake Ave.</b>		e. STREET ADDRESS <b>2708 Chelsea Terr.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DOROTHEA C. DENHARD</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1867</b>
9. AGE (In years lost birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frederick Feldner</b>		14. MOTHER'S MAIDEN NAME <b>Dorothea Plitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Elbert E. Denhard - 2708 Chelsea Terr.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decompensative Cardio Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture left femur</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 24, 1959</b> to <b>June 30, 1959</b> , that I last saw the deceased alive on <b>June 30, 1959</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Laurence C. Post</b>		ADDRESS (Street, city or town, state) <b>6805 York Rd. Baltimore 12 Md.</b>	
PHYSICIAN'S NAME (Type) <b>LAURENCE C. POST</b>		DATE SIGNED <b>7/1/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/2/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>London Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. G. Tinkner &amp; Sons - Balto.</b>		ADDRESS <b>17th</b>	
24a. REC'D BY REGISTRAR <b>JUL 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>	

00303

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

C838

MD-100-155

DATE OF DEATH

DECEASED

PLACE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

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6394

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ma.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>53 Dundalk</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1819 Kinship Road</i>		d. STREET ADDRESS <i>1819 Kinship Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Frederick</i> Middle <i>Carl</i> Last <i>Dietz</i>		4. DATE OF DEATH Month <i>June</i> Day <i>26th</i> Year <i>19 59</i>	
5. SEX <i>male</i> <i>White</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 9, 1888</i>
9. AGE (In years last birthday) yrs. <i>70</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Maintenance Man</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frederick Carl Dietz</i>		14. MOTHER'S MAIDEN NAME <i>Catherine</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs Ethel M. Killens</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Fibrillation</i> DUE TO (c) <i>Arteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1</i> <i>June 1956</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1956</i> to <i>June 26, 1959</i> , that I last saw the deceased alive on <i>6/29/59</i> , 19 <i>9pm</i> , and that death occurred at <i>12 M</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Oswald Berrios MD</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>2703 N. Woodm... Baltimore, Md. Salt Lake City</i>	
PHYSICIAN'S NAME (Type) <i>Oswald Berrios MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-30-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 29 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1.12 FilmG244 7-7-59 et

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>4 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Private residence</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>E.</b> Last <b>Donnelly</b>				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 9, 1871</b>	
9. AGE (In years lost birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bavaria, Germany</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Eydelloth</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Loeffler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>XXXX Mrs. John H. Lawrence 6308 Blenheim Rd.</b>			
17. INFANT <b>XXXX Mrs. John H. Lawrence 6308 Blenheim Rd.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>?</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 28, 1958</b> to <b>Jan 28, 1959</b> , that I last saw the deceased alive on <b>Jan 24, 1959</b> , and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6100 YORK RD BALTO-12 Md</b> DATE SIGNED <b>6/29/59</b>							
ACTUAL SIGNATURE <b>Frederick J. Vollmer</b>				M.D. <b>6100 YORK RD</b>			
PHYSICIAN'S NAME (Type) <b>FREDERICK J. VOLLMER</b>				<b>BALTO-12 Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 1, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. H. Meen+son 805 N. Calvert St</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 1 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							

CERTIFICATE OF DEATH

1933

Page No. 12

DATE OF DEATH

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DECEASED

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## 6438 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN TB <u>25 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bertha</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-10-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nursemaid</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>84</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Stephen Dorschel</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Schwen deman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Emma Dorschel</u>		Address <u>5810 Margaretta</u> <u>Pittsburg Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease infarct</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>long standing</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malnutrition</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1958</u> to <u>June 28, 1959</u> , that I last saw the deceased alive on <u>June 28, 1959</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		DATE SIGNED <u>6-29-59</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M.D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Old St. Paul's</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Balto. 2, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 6439 CERTIFICATE OF DEATH

06425

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>	LENGTH OF STAY (in this place) <u>68 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Old Hanover Road</u>		STREET ADDRESS (If rural give location) <u>Old Hanover Road</u>	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
(First) <u>Julia</u> (Middle) <u>Ellen</u> (Last) <u>Duncan</u>		<u>June 21</u> 19 <u>59</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>W</u>	<b>8. DATE OF BIRTH</b> <u>Sept 30 1869</u>
		<b>9. AGE last birthday</b> <u>89</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>
		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>William H Belt</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ann Brown</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	<b>17. INFORMANT &amp; ADDRESS</b> <u>Marion O Duncan Reisterstown Md</u>
<b>18. MEDICAL CERTIFICATION</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
<b>331X IMMEDIATE CAUSE (A)</b> <u>Cerebral Hemorrhage</u>			<u>4 hrs.</u>
<b>ANTECEDENT CAUSE(S) DUE TO</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B) <u>none</u>			
<b>(C)</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<u>none</u>			
<b>19a. DATE OF OPERATION</b> <u>no</u>	<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>none</u>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <u>none</u>	<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> <u>none</u>	<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State) <u>none</u>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <u>none</u>	<b>21a. INJURY OCCURRED</b> White <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> <u>none</u>	
<b>22. I hereby certify that I attended the deceased from</b> <u>4-20-41</u> , 19....., to <u>6-21-59</u> , 19....., that I last saw the deceased alive on <u>6-21-59</u> , 19....., and that death occurred at <u>5 P.</u> M., from the causes and on the date stated above.			
<b>SIGNATURE</b> <u>D. D. Caples</u>		<b>ADDRESS</b> (Street, city, town, state) <u>6 Hanover Rd. Reisterstown, Md</u>	<b>DATE SIGNED</b> <u>6-23-59</u>
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>	<b>DATE THEREOF</b> <u>June 24 1959</u>	<b>NAME OF CEMETERY OR CREMATORY</b> <u>Reisterstown Mehh Cem Reisterstown Md</u>	<b>LOCATION</b> (City, town, or county) (State) <u>Reisterstown Md</u>
<b>24. REC'D BY REGISTRAR</b> <u>JUN 25 '59</u>	<b>REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kears</u>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm Berryman &amp; Son</u>	

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

## 6130 CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		SEX Male		AGE 65	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Retired		MARITAL STATUS Married	
DATE OF DEATH Jan 15, 1960		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		SIGNATURE OF DECEASED (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF JURY (None)	

This certificate is to be filled out by the physician or coroner in charge of the case. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland.

6440

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO. CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>6 MO.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>236 ROGERS FORGE RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HERBERT</u> First <u>LEO</u> Middle <u>DUNN</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 14 - 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUILDING BUSINESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES DUNN</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE SHERIDAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>219-10-1617</u>	
17. INFORMANT <u>DOROTHA Z. DUNN - ROGERS FORGE RD</u>		Address <u>236</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heat exhaustion</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic congestive failure &amp; hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 19, 1936</u> to <u>June 30, 1959</u> that I last saw the deceased alive on <u>June 30, 1959</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred H. Ossman</u> M.D.		ADDRESS (Street, city or town, state) <u>1101 St Paul St Balto Md.</u> DATE SIGNED <u>7-1-59</u>	
PHYSICIAN'S NAME (Type) <u>Alfred H. Ossman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-4-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. JENKINS &amp; SONS Co.</u> ADDRESS <u>4905 York Rd Balto. Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

*[Faint bleed-through from the reverse side of the page]*

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove caton papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06427

6441

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Dwyer</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1891</u>
9. AGE (In years last birthday) yrs. <u>68</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>pipe fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Gas &amp; Elec.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Dwyer</u>		14. MOTHER'S MAIDEN NAME <u>Annie Schebrecht</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>212-07-6128</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition and dehydration</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 17</u> , 19 <u>59</u> , to <u>June 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 8</u> , 19 <u>59</u> , and that death occurred at <u>3:00a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u> <u>6-8-59</u>			
ACTUAL SIGNATURE <u>Bruno Radauskas</u>		M.D. <u>SPRING GROVE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>Bruno Radauskas, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-11-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. SMITH		2. SEX Male		3. AGE 45	
4. DATE OF DEATH JAN 15 1950		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Salesman		11. EDUCATION High School		12. MARITAL STATUS Married	
13. PREVIOUS ILLNESS None		14. PRESENT ILLNESS None		15. MEDICAL HISTORY None	
16. SIGNATURE OF DECEASED None		17. SIGNATURE OF WITNESSES None		18. SIGNATURE OF PHYSICIAN None	
19. SIGNATURE OF REGISTRAR None		20. SIGNATURE OF CLERK None		21. SIGNATURE OF JURY None	
22. SIGNATURE OF JURY None		23. SIGNATURE OF JURY None		24. SIGNATURE OF JURY None	
25. SIGNATURE OF JURY None		26. SIGNATURE OF JURY None		27. SIGNATURE OF JURY None	
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06428

6443

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Baltimore City</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>			d. STREET ADDRESS <u>3818 Bell Ave., Zone 15</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Edward Ederr</u>			4. DATE OF DEATH Month Day Year <u>June 10 19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-91</u>		9. AGE (In years last birthday) <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles Ederr</u>			14. MOTHER'S MAIDEN NAME <u>Sylvia</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records Spring Grove</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchial Pneumonia</u> <u>450.0</u> DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro-vascular accident 3 years ago</u>					INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>May 8</u> , 19 <u>59</u> , to <u>June 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 10</u> , 19 <u>59</u> , and that death occurred at <u>8 P</u> . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>James Donald Drinkard</u>		M.D. <u>Spring Grove State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>James Donald Drinkard, M.D.</u>		<u>Catonsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		22b. DATE THEREOF <u>6-11-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>United Hebrew</u>	
22d. LOCATION (City, town, county) (State) <u>Balto Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Center Pl</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1-19

<p>1. NAME OF DECEASED                  [Faint text, possibly "John Doe"]</p>		<p>2. SEX                  [Faint text, possibly "Male"]</p>		<p>3. AGE                  [Faint text, possibly "45"]</p>		<p>4. DATE OF DEATH                  [Faint text, possibly "10-15-1918"]</p>	
<p>5. PLACE OF DEATH                  [Faint text, possibly "Home"]</p>		<p>6. CAUSE OF DEATH                  [Faint text, possibly "Heart Disease"]</p>		<p>7. MANNER OF DEATH                  [Faint text, possibly "Natural"]</p>		<p>8. SIGNATURE OF PHYSICIAN                  [Faint signature]</p>	
<p>9. SIGNATURE OF WITNESS                  [Faint signature]</p>		<p>10. SIGNATURE OF DECEASED                  [Faint signature]</p>		<p>11. SIGNATURE OF REGISTRAR                  [Faint signature]</p>		<p>12. SIGNATURE OF CLERK                  [Faint signature]</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. AND A COPY OF IT IS TO BE FURNISHED TO THE CLERK OF THE COURT OF COMMON PLEAS, BALTIMORE, MD.

1  
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06429

6442

Item 12 Film G243 6-16-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Newburg Ave</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville 52</i> d. STREET ADDRESS <i>409 Newburg Ave.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>GUSTAV W. EKLOF</i> First Middle Last		4. DATE OF DEATH Month <i>6</i> Day <i>7</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5 27 79</i>
9. AGE (In years lost birthday) <i>80</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Business</i>	11. BIRTHPLACE (State or foreign country) <i>Denmark</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Business</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Elec.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>—</i>		14. MOTHER'S MAIDEN NAME <i>—</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Wm. Eklof.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Embolism</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Auricular Fibrillation</i> (c) <i>Arterio-sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hr.</i> <i>5 months</i> <i>10 yrs?</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8.16.49</i> to <i>6.7.59</i> , that I last saw the deceased alive on <i>6.7.59</i> , and that death occurred at <i>805 Frederick Ave</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George E. Urban</i> M.D.		ADDRESS (Street, city or town, state) <i>805 Frederick Ave 28 Md</i>	
PHYSICIAN'S NAME (Type) <i>George E. URBAN</i>		DATE SIGNED <i>6.7.59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6 10 59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Good Shepherd</i>		22d. LOCATION (City, town, or county) (State) <i>Howard Co. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don 28</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 11 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Christina S. Kinn</i>			

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06451

6463

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>41 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mission Helpers of the Sacred Heart</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sister Mary Helena (Enea)</b>		4. DATE OF DEATH Month Day Year <b>June 2nd. 1959 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1st. 1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nun</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Convent</b>	
11. BIRTHPLACE (State or foreign country) <b>Sferracvallo, Palermo, Italy.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cosimo Enea</b>		14. MOTHER'S MAIDEN NAME <b>Pietrina Vassallo</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT Address <b>Convent Records, 1001 W. Joppa Rd. Towson</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>455X</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Septicemia from</b> DUE TO <b>Septicemia from</b> (c) <b>Septicemia from</b> DUE TO <b>Septicemia from</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6 weeks</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road</b> DATE SIGNED <b>6/2/59</b>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/4/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Convent Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>1001 W. Joppa Rd. Towson, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Vernon Lemmon</b> ADDRESS <b>4611 Park Heights Ave.</b>		24a. REC'D BY REGISTRAR <b>JUN 3 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

CERTIFICATE OF DEATH

1943

Name of Deceased JAMES H. TOWNSON		Age 51 years		Sex Male	
Date of Death April 1, 1943		Place of Death Home		Cause of Death Heart Disease	
Occupation None		Usual Residence None		Place of Birth None	
Manner of Death None		Medical History None		Previous Illnesses None	
Signature of Physician None		Signature of Registrar None		Signature of Coroner None	
Date of Report April 1, 1943		Place of Report None		Signature of Reporter None	

6444  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Harford Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cotonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i> 1231-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Summit Home</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Louise</i> Middle <i>ETPLER</i> Last		4. DATE OF DEATH Month <i>6</i> Day <i>9</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-6-1893</i>
9. AGE (In years last birthday) <i>86</i> yrs.		10. UNDER 1 YEAR Months <i>7</i> Days	11. UNDER 24 HRS. Hours <i>12</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William C. Hilary</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Kennedy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>William Hilary - Clifton Va</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO <i>Acute &amp; chronic Congestive Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arterio-Sclerotic Cardio-</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Vascular Disease</i> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>25 July 56</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>6/9/59</i>	
21. I certify that I attended the deceased from <i>6/7/59</i> , 19 <i>59</i> , to <i>6/9/59</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>6/7/59</i> , 19 <i>59</i> , and that death occurred at <i>7:20 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.E. McGreth</i>		ADDRESS (Street, city or town, state) <i>1303 Frederick Rd</i> DATE SIGNED <i>6/11/59</i>	
PHYSICIAN'S NAME (Type) <i>W.E. McGreth</i>		<i>Cotonsville 28md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/12/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Shore Presbyterian Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Aberdeen - Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Nabbs</i> ADDRESS <i>St. Michaels &amp; Wade Ave</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 15 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles E. Kraus</i>

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



06431

## 6445 CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> o. COUNTY      Baltimore <div style="text-align: right;">MARYLAND</div>						<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE      Maryland b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Catonsville				2yrllmthl7dys				Baltimore 3V01-4					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM?							
SPRING GROVE STATE HOSPITAL						2335 Linden Avenue YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print)						<b>4. DATE OF DEATH</b>		Month Day Year					
First Middle Last Gladys Farnen						June		1 19 59					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
female		white				December 26, 1885		73					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)					
housewife								Canada Canada ✓					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME							
Unknown						Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address									
Unknown		Unknown		Records:		SPRING GROVE STATE HOSPITAL							
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Generalized arteriosclerosis DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 5, 1959, to June 1, 1959, that I last saw the deceased alive on June 1, 1959, and that death occurred at 2:00 AM, from the causes and on the date stated above.													
ACTUAL SIGNATURE Stella Wachslar				DATE SIGNED SPRING GROVE STATE HOSPITAL 6-1-59									
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				ADDRESS (Street, city or town, state) Catonsville 28, Maryland									
22a. BURIAL, CREMATION, REMOVAL(Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)*					
Burial				6/3/59		Cathedral		Woodbrook Frederick					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS						24a. REC'D BY REGISTRAR DATE JUN 3 '59		24b..REGISTRAR'S SIGNATURE John E. ...					

VS A15 (4)  
15M 10/57

10-10-31

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1931

THE STATE OF MARYLAND

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

10-10-31

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		10-10-31		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Artery Disease		Natural		Home	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
10-10-31		10:00 AM		Home		[Signature]		[Signature]	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Health Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06432

6446

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3502 Orchard Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>S.</b> Last <b>FEARS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1, 1891</b>		9. AGE (In years last birthday) <b>68</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Adam Stein</b>				14. MOTHER'S MAIDEN NAME <b>Mary Lowrey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Charles C. Fears-3502 Orchard Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pressure hemorrhage - Intracerebral</b> DUE TO <b>Colitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Colitis</b> DUE TO (c) <b>Colitis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b> <b>10 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>March 10, 1953</b> to <b>June 22, 1959</b> , that I last saw the deceased alive on <b>June 19, 1959</b> , and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edwin L. Pierpont</b>				ADDRESS (Street, city or town, state) <b>8204 LIBERTY RD, BALTO. 7, Md</b>			
PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, M.D.</b>				DATE SIGNED <b>6/23/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>June 25, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>WOODLAWN, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons-Balto 17</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kinard</b>	



## 6447 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS <u>4115 Hayward Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Anne</u> Last <u>Forney</u>				4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>19 59</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 8, 1865</u>		9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.	Month, Day, Year <u>19 59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>May 20</u> , 19 <u>59</u> , to <u>June 10</u> , 19 <u>59</u> that I last saw the deceased alive on <u>June 10</u> , 19 <u>59</u> , and that death occurred at <u>8:30 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>6-10-59</u>			
PHYSICIAN'S NAME (Type) <u>Bruno Radauskas</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 13/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) <u>Woodlawn Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Ammest</u>				ADDRESS <u>4204 - Ridgewood cove.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 11 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*[Faint, illegible text from bleed-through]*

## 6448 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		BALTIMORE		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		BALTIMORE			
c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		4303 Wilkens Avenue			
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE		b. COUNTY	
Maryland		BALTIMORE			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		BALTIMORE			
d. STREET ADDRESS		4303 Wilkens Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle	
William Henry Fosbrink, Sr.		Last		4. DATE OF DEATH	
June 5, 1959		Month		Day	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
male		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR	
Oct. 4, 1883		75		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ret. Policeman				Baltimore County	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U. S. A.		William Fosbrink		Barbara Dimling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT	
no				Edna L. Fosbrink 4303 Wilkens Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
177X		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)			
		DUE TO			
		(c) Carcinoma of Prostate gland		3 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour o. m. p. m.		While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		(City or town) (County) (State)	
21. I certify that I attended the deceased from 3 April, 1959, to 5 June, 1959, that I last saw the deceased alive on 3 June, 1959, and that death occurred at 8 A.M., from the causes and on the date stated above.		22. LOCATION (City, town, or county) (State)		DATE SIGNED	
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)			
Irwin H. Moss		5836 Balto. Natl. Pike			
PHYSICIAN'S NAME (Type)		Baltimore 28, Maryland			
Irwin H. Moss, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial		6/8/59		Western Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Howard H. Hubbard 4107 Wilkens Avenue		DATE JUN 8 '59		Arthur S. Kraus	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 10/57

[illegible]

## 6449 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upperco</b>		c. LENGTH OF STAY IN 1b <b>60 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arcadia</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Cyril</b> Middle <b>Elmo</b> Last <b>Fowble</b>		4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 31, 1874</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John T. Fowble</b>		14. MOTHER'S MAIDEN NAME <b>Eliza N. Gill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Geneva Fowble, Upperco, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cancer of Prostate</b> DUE TO (c) <b>177X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m. <b>none</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>8-4-58</b> , 19____, to <b>6-11-59</b> , 19____, that I last saw the deceased alive on <b>6-11-59</b> , 19____, and that death occurred at <b>12 Noon</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>D. D. Caples</b>		ADDRESS (Street, city or town, state) <b>6 Hanover Rd.</b>	
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		DATE SIGNED <b>6-13-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arcadia, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sona, Reisterstown, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BRITISH ISLANDS STATE DEPARTMENT OF HEALTH - BATHING

<p>1. Name of Deceased: <u>John Doe</u></p>		<p>2. Date of Birth: <u>10-10-1910</u></p>	
<p>3. Sex: <u>Male</u></p>		<p>4. Date of Death: <u>10-15-1910</u></p>	
<p>5. Cause of Death: <u>Heart Disease</u></p>		<p>6. Place of Death: <u>Home</u></p>	
<p>7. Signature of Doctor: <u>Dr. J. Smith</u></p>		<p>8. Signature of Registrar: <u>Mr. J. Doe</u></p>	
<p>9. Date of Registration: <u>10-15-1910</u></p>		<p>10. Date of Issuance: <u>10-15-1910</u></p>	

BRITISH ISLANDS STATE DEPARTMENT OF HEALTH - BATHING

BRITISH ISLANDS STATE DEPARTMENT OF HEALTH - BATHING

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 14 Film G244 7-2-59 et

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6450

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Forest Haven Nursing Home</b>		d. STREET ADDRESS <b>5008 Belair Road</b>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>FRENCH</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1874</b>
9. AGE (In years last birthday) yrs. <b>85</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William French</b>		14. MOTHER'S MAIDEN NAME <b>Mary ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mr. John Morawe 2826 Bauernwood Rd. Balto. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X ARTERIO SCLEROTIC CARDIO- VASCULAR RENAL DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>CEREBRO</b> (c) <b>PULMONARY EDEMA</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/1</b> , 19 <b>59</b> , to <b>6/23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/23</b> , 19 <b>59</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>John H. Shaw M.D. 5820 EDWARDS AVE 6/23/59</b>			
ACTUAL SIGNATURE <b>John H. Shaw</b>		PHYSICIAN'S NAME (Type) <b>John H. Shaw M.D. 5820 EDWARDS AVE 6/23/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/26/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Which Funeral Home</b>		24a. REC'D BY REGISTRAR <b>4210 Belair Rd. Balto</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		DATE <b>JUN 30 '59</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05100

TESTIMONY OF DEATH

0230

1

Witness

Witness

Witness

Witness

Witness

Witness

Witness

Witness

Witness

Witness

1

6451

## CERTIFICATE OF DEATH

06437

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>		d. STREET ADDRESS <b>Glenarm Road</b>	
3. NAME OF DECEASED (Type or print) <b>Sister Mary Frederick Frisch</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 21, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>	
11. BIRTHPLACE (State or foreign country) <b>Rochester, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Frisch</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Weiss</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sr. M. Peter Fourier</b>		Address <b>Notch Cliff, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decompensation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterial Cardiac Renal Vascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 19 52</b> to <b>June 19 59</b> , that I last saw the deceased alive on <b>June 23 19 59</b> , and that death occurred at <b>4:50 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		ADDRESS (Street, city or town, state) <b>7501 York Road Towson Md.</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>		DATE SIGNED <b>6/29/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL 7-1-59.</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>VILLA MARIA CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>NOTCHCLIFF NR TOWSON, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles L. Giller</i>		ADDRESS <b>9015 CONKLING ST. BALTO., MD.</b>	
24a. REC'D BY REGISTRAR <b>JUL 1 1959</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6452 CERTIFICATE OF DEATH

06438

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>				c. LENGTH OF STAY IN 1b <b>21 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Featherbed Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Rufus</b> Middle <b>Wilson</b> Last <b>Fritz</b>				4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 13, 1874</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min. <b>85</b>		IF UNDER 24 HRS. Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min. <b>85</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor at Cotton Mill</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Penna.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	
13. FATHER'S NAME <b>Simon P. Fritz</b>				14. MOTHER'S MAIDEN NAME <b>Martha S. Dull</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-22-5974</b>		17. INFORMANT <b>Dewey S. Fritz, Owings Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Ca. of Lungs</b> DUE TO <b>Cancer of Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 yrs.</b> (c) <b>3 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>170X</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Pikesville</b>				20g. (County) <b>Pikesville</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Sept. 1954</b> , to <b>June 30th, 1959</b> , that I last saw the deceased alive on <b>June 8th, 1959</b> , and that death occurred at <b>8:20 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1331 Reisterstown Rd., Pikesville - P. Md.</b> DATE SIGNED <b>7/1/59</b>							
ACTUAL SIGNATURE <b>James A. Miller M.D.</b>				PHYSICIAN'S NAME (Type) <b>James A. Miller M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>July 3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	
22d. LOCATION (City, town, or county) <b>Pikesville, Md.</b>				22e. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		22f. ADDRESS <b>Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 1 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kiser</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF MINISTER		SIGNATURE OF CLERGY	
SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
SIGNATURE OF CLERK		SIGNATURE OF RECORDS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF MINISTER		SIGNATURE OF CLERGY	
SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
SIGNATURE OF CLERK		SIGNATURE OF RECORDS	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6453 CERTIFICATE OF DEATH

06439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN TB <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED <b>SERVED AS:</b> First <b>JAMES H.</b> Middle <b>GALLOWAY</b> Last <b>GALLOWAY</b> (Type or print)		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile Factory</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>James Galloway</b>		14. MOTHER'S MAIDEN NAME <b>Martina Wade</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>718-09-0455</b>	
17. INFORMANT <b>Clinical Rec., VA Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>420.0</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>420.0</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X</b> <b>PULMONARY TUBERCULOSIS, NOT CONFIRMED</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 25</b> , 19 <b>59</b> , to <b>June 27</b> , 19 <b>59</b> , and that death occurred at <b>4:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA Hospital, Ft. Howard, Md.</b> DATE SIGNED <b>6/28/59</b>			
ACTUAL SIGNATURE <b>Moses Lichtig, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Moses Lichtig, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-1-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George H. Nelson</b>		24a. REC'D BY REGISTRAR <b>JUN 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kline</b>		24c. REGISTRAR'S SIGNATURE	

GEO. G. KELSON FUNERAL HOME, 1348 N. CALHOUN ST., BALTO., MD.

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

## CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. GILBERT		SEX Male		AGE 65	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH Jan. 1, 1890		PLACE OF DEATH Baltimore, Md.	
OCCUPATION Clerk		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
DATE OF DEATH Jan. 15, 1955		TIME OF DEATH 10:30 A.M.		PLACE OF INTERMENT St. Mary's Cemetery	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES J. Edgar Hoover, M.D. J. Edgar Hoover, M.D.		SIGNATURE OF PHYSICIAN J. Edgar Hoover, M.D.	
SIGNATURE OF CORONER J. Edgar Hoover, M.D.		SIGNATURE OF JURY J. Edgar Hoover, M.D.		SIGNATURE OF STATE DEPARTMENT OF HEALTH J. Edgar Hoover, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6395

## CERTIFICATE OF DEATH

06440

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1815 MAXWELL Ave.</u>		d. STREET ADDRESS <u>1815 MAXWELL Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>VONDER GATTON</u>		4. DATE OF DEATH Month Day Year <u>JUNE 1 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/23/1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seed Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARCELLUS GATTON</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Magill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>214-18-0910</u>	
17. INFORMANT Address <u>MRS. JOHN A. Legere</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF FACE</u> <u>191.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV. 1950</u> , to <u>5/31/59</u> , that I last saw the deceased alive on <u>5/31/59</u> , and that death occurred at <u>3:35 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>33 Dundalk Avenue</u> DATE SIGNED <u>June 1, 1959</u>			
ACTUAL SIGNATURE <u>W. E. Baermann</u> M.D.			
PHYSICIAN'S NAME (Type) <u>W. E. Baermann, M. D.</u>		<u>Baltimore 22, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 4, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Truman Schuch</u> ADDRESS <u>3512 Federal Ave. (29)</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 4 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1938

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

105440

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
HARRIS		M		35		JAN 15 1903	
PLACE OF BIRTH		RACE		OCCUPATION		EDUCATION	
BALTIMORE, MARYLAND		WHITE		LABORER		8 YEARS	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
JAN 20 1938		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL	
TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
10:00 AM		100.0		60		20	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1938		JAN 20 1938		JAN 20 1938		JAN 20 1938	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
JAN 20 1938		JAN 20 1938		JAN 20 1938		JAN 20 1938	
TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM		10:00 AM		10:00 AM	
TEMPERATURE		TEMPERATURE		TEMPERATURE		TEMPERATURE	
100.0		100.0		100.0		100.0	
PULSE		PULSE		PULSE		PULSE	
60		60		60		60	
RESPIRATION		RESPIRATION		RESPIRATION		RESPIRATION	
20		20		20		20	

ORIGINAL FILED IN 105440

RECEIVED JAN 21 1938

RECEIVED JAN 21 1938

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G244 7/9/59 cap

6454

## CERTIFICATE OF DEATH

06441

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Adm</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>3 mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>				e. STREET ADDRESS <u>35 Jefferson Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>H</u> Last <u>Gauss</u>				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 26, 1885</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Gauss</u>				14. MOTHER'S MAIDEN NAME <u>ALVARETTA GREEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs Reginald B Chambers Sr.</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Lobar Pneumonia</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary edema</u> DUE TO (c) <u>Cardiac failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>4 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> 19 <u>59</u> , to <u>June 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 30</u> , 19 <u>59</u> , and that death occurred at <u>7:45</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4605 Edmond Ave</u> DATE SIGNED <u>7/1/59</u>							
ACTUAL SIGNATURE <u>Cliff Ratliff, Sr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, SR.</u> <u>BALTIMORE 29, Md.</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR, SON</u>				ADDRESS <u>ANNAPOLIS MD</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6455 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3a, 2a, 2c & 2d, Film G-245 7/17/59.cac.

Reg. Dist. No.

06442

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>South Carolina</b> COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson Georgetown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1106 Concordia Drive</b>		d. STREET ADDRESS <b>305 Meeting Street</b> <b>1106 Concordia Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>ROSE</b> Last <b>GRADY</b> <b>GEAGAN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1892</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Houx</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Blackshear Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J. L. Grady</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT Address <b>Mrs. Jane Asserson, 2929 N. Calvert Street</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b> <b>420.1</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease.</b> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>6-26-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prince George Church Yard Cemetery, Georgetown, S.C.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Towson, Inc., 1050 York Road, Towson</b>		24a. REC'D BY REGISTRAR <b>JUN 29 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	



6455

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>				c. LENGTH OF STAY IN 1b <u>12 yrs.</u> x <u>Rural-Parkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old York Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Beulah Dorothy Gibbs</u>				4. DATE OF DEATH <u>June 24, 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 14, 1902</u> 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elec. Terminals</u>		11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John H Walbeck</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Simmes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-14-5662</u>		17. INFORMANT <u>Harry C Gibbs, Parkton Md. e.o.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DIA BYTES MELLITUS -</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA - ARTERIO-SCLEROTIC CARDIA VASCULAR DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>6-1</u> , 19 <u>59</u> , to <u>6-24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-24</u> , 19 <u>59</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Herbert Mueller Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>York Rd., Thierford (PARKTON P.O.) Md.</u>			
PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER Jr.</u>				DATE SIGNED <u>June 25, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 27/1959</u>		<u>Stewartstown Cemetery</u>		<u>Stewartstown, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Hartenstein</u>				ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
				DATE <u>JUN 30 '59</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: Mary Jane Smith]		SEX [Handwritten: Female]		AGE [Handwritten: 65]	
PLACE OF BIRTH [Handwritten: Baltimore, Md.]		DATE OF BIRTH [Handwritten: Jan 15, 1880]		PLACE OF DEATH [Handwritten: Baltimore, Md.]	
OCCUPATION [Handwritten: None]		CAUSE OF DEATH [Handwritten: Heart Failure]		MANNER OF DEATH [Handwritten: Natural]	
TIME OF DEATH [Handwritten: 10:30 AM]		DATE OF DEATH [Handwritten: Dec 10, 1945]		PLACE OF INTERMENT [Handwritten: St. Mary's Cemetery]	
SIGNATURE OF PHYSICIAN [Handwritten: J. H. Smith]		SIGNATURE OF CLERK [Handwritten: J. H. Smith]		SIGNATURE OF WITNESS [Handwritten: J. H. Smith]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF NEXT OF KIN [Handwritten: J. H. Smith]		SIGNATURE OF BURIAL OFFICIAL [Handwritten: J. H. Smith]	

1

10 MOMENT OF DEATH'S OCCURRENCE, IF NOT KNOWN, GIVE TIME OF DEATH IN APPROXIMATE TERMS.  
 10 SIGNATURE OF PHYSICIAN, CLERK, WITNESS, NEXT OF KIN, AND BURIAL OFFICIAL.  
 10 SIGNATURE OF DECEASED, IF KNOWN.  
 10 SIGNATURE OF PHYSICIAN, CLERK, WITNESS, NEXT OF KIN, AND BURIAL OFFICIAL.  
 10 SIGNATURE OF DECEASED, IF KNOWN.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6457

## CERTIFICATE OF DEATH

06444

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u> c. LENGTH OF STAY IN lb <u>6 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>912 ADANA Rd.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X PIKESVILLE</u> d. STREET ADDRESS <u>912 ADANA Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>CHRISTINE</u> First <u>LANGEVIN</u> Middle <u>GILLETTE</u> Last				<b>4. DATE OF DEATH</b> <u>6-20-</u> Month <u>1959</u> Day Year			
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>11-9-1881</u>	
<b>9. AGE</b> (In years last birthday) <u>77</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>HOME</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>NEW JERSEY</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>NEILS STAAGARD PETERSEN</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>ANDREA A. BECK</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>069-10-4808</u>		<b>17. INFORMANT</b> <u>ADELINE LANGEVIN NEY-912 ADANA</u> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>10 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 hour</u> (b) <u>10 years</u> (c)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>*****</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>*****</u>				<b>20f. (City or town)</b> (County) (State) <u>*****</u>			
<b>21. I certify</b> that I attended the deceased from <u>1 October</u> , 19 <u>58</u> , to <u>Present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19 March</u> , 19 <u>59</u> , and that death occurred at <u>9:00AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5101 Gwynn Oak Avenue,</u> DATE SIGNED <u>20 June 1959</u>							
<b>ACTUAL SIGNATURE</b> <u>Millard T. Traband, Jr.</u> M.D.				<b>PHYSICIAN'S NAME (Type)</b> <u>Millard T. Traband, Jr.</u> <u>Baltimore, 7, Maryland</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>DUPIAL</u>		<b>22b. DATE THEREOF</b> <u>6-23-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>PARKVIEW</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Schenectady New York</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Frank H. Powell, Pikesville 8, Md.</u> ADDRESS				<b>24a. REC'D BY REGISTRAR</b> <u>JUN 23 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Orlana S. Kiana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

AMERICAN STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>1. Name of deceased (Print name and last name)                  _____</p>		<p>2. Sex                  _____</p>	
<p>3. Date of birth (Month, day, year)                  _____</p>		<p>4. Place of birth (City, State, Country)                  _____</p>	
<p>5. Date of death (Month, day, year)                  _____</p>		<p>6. Place of death (City, State, Country)                  _____</p>	
<p>7. Cause of death (Specify)                  _____</p>		<p>8. Manner of death (Specify)                  _____</p>	
<p>9. Signature of physician (Print name)                  _____</p>		<p>10. Signature of registrar (Print name)                  _____</p>	

<p>11. Name of informant (Print name)                  _____</p>		<p>12. Address of informant (City, State, Country)                  _____</p>	
<p>13. Date of completion of certificate (Month, day, year)                  _____</p>		<p>14. Signature of informant (Print name)                  _____</p>	
<p>15. Signature of registrar (Print name)                  _____</p>		<p>16. Signature of physician (Print name)                  _____</p>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6396

CERTIFICATE OF DEATH

06445

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> <b>Turner Station</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Turner Station</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>105 Oak Street</u>		d. STREET ADDRESS <u>105 Oak Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>F.</u> Last <u>Gilliam</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-31-1900</u>	9. AGE (In years last birthday) yrs. <u>59</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>William Fellow</u>		14. MOTHER'S MAIDEN NAME <u>Olive Johnson</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Scott W. Gilliam - 105 Oak Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>334X</u> IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>intermittent</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>June 25/59</u> to <u>June 28/59</u> , that I last saw the deceased alive on <u>June 28/59</u> , and that death occurred at <u>7:15 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Thomas</u> M.D.		ADDRESS (Street, city or town, state) <u>107 N. Main St. Balto. Md.</u>		DATE SIGNED <u>June 28/59</u>	
PHYSICIAN'S NAME (Type) <u>J. H. Thomas M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-2-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Corner Stone Baptist Church</u>	
22d. LOCATION (City, town, or county) (State) <u>Farmville, Virginia</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		ADDRESS <u>802 Madison Avenue</u>	
24a. REC'D BY REGISTRAR <u>DATE JUL 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



## 6458 - CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> ✓ 3001-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Isabel</b> Middle Last <b>Godman</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1869</b>
9. AGE (In years last birthday) yrs. <b>89</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME D. <b>John Godman</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Ann Renard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 29, 1958, to June 16, 1959, that I last saw the deceased alive on June 16, 1959, and that death occurred at 11:30a AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Stella Wachslar M.D. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 6-16-59

PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/18/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickens &amp; Sons - Balt.</u>	ADDRESS <u>mid</u>	24a. REC'D BY REGISTRAR <b>JUN 17 '59</b>	24b. REGISTRAR'S SIGNATURE <u>Carlton A. Harris</u>
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TO HOSPITAL OR A FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

For use in

DEPARTMENT OF HEALTH - BALTIMORE, MD.

<p>1. Name of deceased (Print name and last name)                  _____</p>		<p>2. Sex                  _____</p>	
<p>3. Date of birth (Month, day, year)                  _____</p>		<p>4. Place of birth (City, State, Country)                  _____</p>	
<p>5. Date of death (Month, day, year)                  _____</p>		<p>6. Place of death (City, State, Country)                  _____</p>	
<p>7. Cause of death (List all causes, beginning with immediate cause)                  _____</p>		<p>8. Manner of death (Natural, Accidental, Suicide, Homicide, Undetermined)                  _____</p>	
<p>9. Signature of physician (Print name)                  _____</p>		<p>10. Signature of registrar (Print name)                  _____</p>	
<p>11. Date of completion (Month, day, year)                  _____</p>		<p>12. Place of completion (City, State, Country)                  _____</p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>8 mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor</b>				d. STREET ADDRESS <b>7418 Poplar Ave. #28</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Thomas</b> Last <b>Green</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 59</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 1, 1878</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		11. BIRTHPLACE (State or foreign country) <b>Bethlehem Steel Mt. Alto., Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Thomas Green</b>		14. MOTHER'S MAIDEN NAME <b>MARY MARCH SCHAEFER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-07-5979</b>		17. INFORMANT <b>Mrs. Alma Denny, 7418 Poplar Ave. -24</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.1</b> <b>Damage of severe Extremity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>5 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 19 49</b> , to <b>June 19 59</b> , that I last saw the deceased alive on <b>June 16 19 59</b> , and that death occurred at <b>12:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6014 Edmond Ave</b> DATE SIGNED <b>6-18-59</b>							
ACTUAL SIGNATURE <b>J. Nelson McKay, M.D.</b>				PHYSICIAN'S NAME (Type) <b>J. Nelson McKay, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/20/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Bradley</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

DEATH CERTIFICATE

NAME OF DECEASED MARY ANN BROWN		SEX FEMALE	
DATE OF BIRTH JAN 15 1890		PLACE OF BIRTH BALTIMORE, MD	
DATE OF DEATH DEC 10 1970		PLACE OF DEATH BALTIMORE, MD	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MEDICAL ATTENDANT DR. J. H. SMITH	
SIGNATURE OF DECEASED MARY ANN BROWN		SIGNATURE OF MEDICAL ATTENDANT DR. J. H. SMITH	
SIGNATURE OF NEXT OF KIN JOHN BROWN		SIGNATURE OF REGISTRAR J. H. SMITH	
ADDRESS OF DECEASED 1234 E. MAIN ST. BALTIMORE, MD 21201		ADDRESS OF MEDICAL ATTENDANT 5678 N. BROAD ST. BALTIMORE, MD 21201	
ADDRESS OF NEXT OF KIN 1234 E. MAIN ST. BALTIMORE, MD 21201		ADDRESS OF REGISTRAR 5678 N. BROAD ST. BALTIMORE, MD 21201	

CONFIDENTIAL

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06448

Reg. Dist. No.

6460

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>5yr 11m 14dy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ruth Hoffman</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>53</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Hoffman</b>		14. MOTHER'S MAIDEN NAME <b>Anna Peregoy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>malnutrition &amp; dehydration</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 11, 1958</b> , to <b>June 25, 1958</b> , that I last saw the deceased alive on <b>June 25, 1958</b> , and that death occurred at <b>7:35 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-25-59</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-29-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Towson 4, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 29 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kinas</b>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06449

## 6461 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> 19 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3101 Riverdrive Rd</u>		d. STREET ADDRESS <u>13008 Wells Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LULA V. HALL</u>		4. DATE OF DEATH Month <u>JUN</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver Geoghegan</u>		14. MOTHER'S MAIDEN NAME <u>LULA DICKENSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Howard Hall</u>		Address <u>670 Riverdrive Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno Carcinoma Stomach</u> 151X DUE TO <u>with liver metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Sept. 1958</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 17</u> , 19 <u>59</u> , to <u>June 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 17</u> , 19 <u>59</u> , and that death occurred at <u>3 A</u> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Hallin</u>		ADDRESS (Street, city or town, state) <u>6908 N Pt Rd</u> DATE SIGNED <u>6/22/59</u>	
PHYSICIAN'S NAME (Type) <u>Louis N. TOLIN MD</u>		<u>Balto 19 md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wells Funeral Home</u>		ADDRESS <u>2112 Dundalk</u>	
24a. REC'D BY REGISTRAR <u>JUN 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6462

Item 1 Film G244 7-7-59 at  
**CERTIFICATE OF DEATH**

06450

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>MARYLAND</b> COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 CATONSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Private Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>HARRIS</b> Last <b>HARRIS</b>		4. DATE OF DEATH Month <b>6</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-23-1899</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
11. BIRTHPLACE (State or foreign country) <b>HOWARD COUNTY, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN BROOKS</b>		14. MOTHER'S MAIDEN NAME <b>CLARA JACKSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. NETTIE HARRIS PAGE-1009 ALEX. AV.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO VASCULAR DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ANEURYSM OF AORTA</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/31/</b> 19 <b>59</b> to <b>6/14/</b> 19 <b>59</b> , that I last saw the deceased alive on <b>6-13-</b> 19 <b>59</b> , and that death occurred at <b>10:15 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>403 MEDICAL ARTS BLDG.</b> DATE SIGNED <b>6/14/59</b> ACTUAL SIGNATURE <b>W. R. Johnson</b> M.D. PHYSICIAN'S NAME (Type) <b>W. R. JOHNSON</b> <b>403 MEDICAL ARTS BLDG.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/18/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM'L PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Hooper</b>		24a. REC'D BY REGISTRAR <b>JUN 19 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>			

## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

# Item 7 Film 6244 6-19-59 et 6464 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residencia before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ebenezer Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James Dunlap Hardie</b>				4. DATE OF DEATH Month <b>June 11</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/12/1876</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Beaver Co., Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Hardie</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Dunlap</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>223-224346</b>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CIRRHOSIS OF LIVER</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>3 MONTHS</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>MAR 11, 1959</b> , to <b>JUNE 11, 1959</b> , that I last saw the deceased alive on <b>JUNE 11, 1959</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Louis Semenov</b>		M.D. <b>2108 Orems Rd</b>		ADDRESS (Street, city or town, state) <b>Baltimore 20, Md</b>		DATE SIGNED <b>6/11/59</b>	
PHYSICIAN'S NAME (Type) <b>LOUIS SEMENOFF</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/14/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Family Burial Grds.</b>		22d. LOCATION (City, town, or county) (State) <b>Crewe Va.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 15 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 10/57

Howard H. Hubbard, #107 Wilkens Ave.

Burial 6/14/59 Family Burial Grds. Crewe Va.

Burial

6/14/59

Family Burial Grds.

Crewe Va.

Age

Sex

Color

Height

Weight

Build

Complexion

Hair

Eyes

Mouth

Nostrils

Ears

Teeth

Scars

Other

no 223-224346

James Hardie

Elizabeth Dunlap

Farmer

Beaver Co., Penn.

U. S. A.

male white

4/12/1876

83

James

Dunlap

Hardie

June 11,

59

Ebenezer Rd.

Ebenezer Rd

White Marsh

Baltimore

Maryland

Baltimore

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

## 6465 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2mths13dys</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>			d. STREET ADDRESS <b>3702 Sylvan Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b>Hicks</b> Last <b>Hicks</b>			4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>19 59</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1876</b>		9. AGE (In years last birthday) <b>83</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decompensatory heart disease</b> <b>434.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adherent pericardium - cause unknown</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute pyelonephritis - Generalized arteriosclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 16 19 59</b> to <b>June 29, 19 59</b> , that I last saw the deceased alive on <b>June 29, 19 59</b> , and that death occurred at <b>11:00p M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>		DATE SIGNED <b>6-30-59</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		ADDRESS <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/2/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Young Byers, 8728 Liberty Rd. Randallstown,</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Carling S. Hume</b>					

1  
2

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

10033

CERTIFICATE OF DEATH

Rev. 2-15-1941

1. NAME OF DECEASED JAMES B. BOLD		2. SEX Male		3. AGE 45	
4. PLACE OF BIRTH Baltimore, Md.		5. DATE OF BIRTH Jan 15, 1896		6. PLACE OF DEATH Baltimore, Md.	
7. OCCUPATION Salesman		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF DECEASED (None)		11. SIGNATURE OF WITNESSES J. B. Bold, Jr. J. B. Bold, Sr.		12. SIGNATURE OF PHYSICIAN J. B. Bold, M.D.	
13. DATE OF DEATH Jan 15, 1941		14. TIME OF DEATH 10:30 AM		15. PLACE OF BURIAL Baltimore, Md.	
16. NAME OF FUNERAL HOME J. B. Bold & Co.		17. NAME OF MINISTER J. B. Bold		18. NAME OF CHURCH St. Paul's Church	
19. NAME OF CEMETERY St. Paul's Cemetery		20. NAME OF INTERMENT J. B. Bold		21. NAME OF BURIAL J. B. Bold	
22. NAME OF CREMATOR None		23. NAME OF CREMATION None		24. NAME OF CREMATION None	
25. NAME OF CREMATION None		26. NAME OF CREMATION None		27. NAME OF CREMATION None	
28. NAME OF CREMATION None		29. NAME OF CREMATION None		30. NAME OF CREMATION None	
31. NAME OF CREMATION None		32. NAME OF CREMATION None		33. NAME OF CREMATION None	
34. NAME OF CREMATION None		35. NAME OF CREMATION None		36. NAME OF CREMATION None	
37. NAME OF CREMATION None		38. NAME OF CREMATION None		39. NAME OF CREMATION None	
40. NAME OF CREMATION None		41. NAME OF CREMATION None		42. NAME OF CREMATION None	
43. NAME OF CREMATION None		44. NAME OF CREMATION None		45. NAME OF CREMATION None	
46. NAME OF CREMATION None		47. NAME OF CREMATION None		48. NAME OF CREMATION None	
49. NAME OF CREMATION None		50. NAME OF CREMATION None		51. NAME OF CREMATION None	
52. NAME OF CREMATION None		53. NAME OF CREMATION None		54. NAME OF CREMATION None	
55. NAME OF CREMATION None		56. NAME OF CREMATION None		57. NAME OF CREMATION None	
58. NAME OF CREMATION None		59. NAME OF CREMATION None		60. NAME OF CREMATION None	
61. NAME OF CREMATION None		62. NAME OF CREMATION None		63. NAME OF CREMATION None	
64. NAME OF CREMATION None		65. NAME OF CREMATION None		66. NAME OF CREMATION None	
67. NAME OF CREMATION None		68. NAME OF CREMATION None		69. NAME OF CREMATION None	
70. NAME OF CREMATION None		71. NAME OF CREMATION None		72. NAME OF CREMATION None	
73. NAME OF CREMATION None		74. NAME OF CREMATION None		75. NAME OF CREMATION None	
76. NAME OF CREMATION None		77. NAME OF CREMATION None		78. NAME OF CREMATION None	
79. NAME OF CREMATION None		80. NAME OF CREMATION None		81. NAME OF CREMATION None	
82. NAME OF CREMATION None		83. NAME OF CREMATION None		84. NAME OF CREMATION None	
85. NAME OF CREMATION None		86. NAME OF CREMATION None		87. NAME OF CREMATION None	
88. NAME OF CREMATION None		89. NAME OF CREMATION None		90. NAME OF CREMATION None	
91. NAME OF CREMATION None		92. NAME OF CREMATION None		93. NAME OF CREMATION None	
94. NAME OF CREMATION None		95. NAME OF CREMATION None		96. NAME OF CREMATION None	
97. NAME OF CREMATION None		98. NAME OF CREMATION None		99. NAME OF CREMATION None	
100. NAME OF CREMATION None		101. NAME OF CREMATION None		102. NAME OF CREMATION None	

10033

10033

6466

## CERTIFICATE OF DEATH

06454

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3003 PUTTY HILL AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>H</u> Last <u>HOFFMAN</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 7 1898</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Holland</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE HENRY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-24-7288</u>	
17. INFORMANT <u>JAMES R Sappington</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u> <u>5 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>58</u> , to <u>June 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>59</u> , and that death occurred at <u>10 PM</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2810 TAYLOR-AVE - BALTO. - MD.</u> DATE SIGNED <u>6/6/59</u>			
ACTUAL SIGNATURE <u>G. M. Bacon</u>		M.D. <u>2810 TAYLOR-AVE - BALTO. - MD.</u>	
PHYSICIAN'S NAME (Type) <u>A. M. BACON</u>		<u>BALTO. - MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 8-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>	22d. LOCATION (City, town, or county) <u>BALTIMORE</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F. EVANS &amp; SON</u> ADDRESS <u>8802 HARTFORD RD</u>		24a. REC'D BY REGISTRAR <u>JUN 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6397 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06455

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 22</b>		c. LENGTH OF STAY IN 1b <b>18 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk 22</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2482 Keyway</b>				d. STREET ADDRESS <b>2482 Keyway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>+++</b> Last <b>HUBER, JR.</b>				4. DATE OF DEATH Month <b>June</b> Day <b>25th</b> Year <b>19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1893</b>		9. AGE (in years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Banbury Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Huber, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ruppert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-01-9219</b>		17. INFORMANT <b>Mrs. Anna S. Huber</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Corny Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>A-S-C-U Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/26/59</b>			
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2157-1754

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G243 6-12-59 et

6467

CERTIFICATE OF DEATH

06456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freeland - Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freeland, - Rural</u>	
c. LENGTH OF STAY IN 1b <u>23 yrs.</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Walker Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5. STREET ADDRESS <u>1 Walker Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>B.</u> Last <u>JACOBS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James B. Jacobs</u>		14. MOTHER'S MAIDEN NAME <u>Susan B. Boyles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Heta Horstellor</u>		Address <u>Freeland Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO <u>334X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>July 3, 1933</u> to <u>June 3, 1959</u> , that I last saw the deceased alive on <u>June 2, 1959</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
DATE SIGNED <u>  </u>			
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 7, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hampstead, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Klaus</u>	
DATE <u>JUN 8 '59</u>			



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06457

## 6468 CERTIFICATE OF DEATH

Reg. Dist. No.

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN		<u>4 years</u>		TOWN <u>Mechanicsville</u>		<u>18x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mercy Villa Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Etta</u> (Middle) <u>Elizabeth</u> (Last) <u>Jarboe</u>				(Month) <u>June</u> (Day) <u>23</u> (Year) <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Nov. 21, 1895</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>DAVID DAWSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY M. RALEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>PAUL E. JARBOE, 5307 KENILWORTH AVE., BALTO 12 MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>ENCEPHALOMALACIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DIS</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>FEB 14, 1955</u> , to <u>JUN 23, 1959</u> , that I last saw the deceased alive on <u>JUN 23, 1959</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frederick J. Valence</u>				ADDRESS (Street, city, town, state) <u>6100 YORK RD. BALTO-12 MD.</u> DATE SIGNED <u>6/23/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6-26-59</u>		NAME OF CEMETERY OR CREMATORY <u>ST. Joseph</u>		LOCATION (City, town, or county) (State) <u>MORGANZA, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson</u>		ADDRESS <u>Baltimore Md.</u>	
DATE <u>JUL 2 '59</u>							



6469

CERTIFICATE OF DEATH

06458

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>302 S. Rolling Rd.</i>		d. STREET ADDRESS <i>1302 S. Rolling Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Raymond C. Jenkins</i> First Middle Last		4. DATE OF DEATH <i>June 3 1959</i> Month Day Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/26/194</i> 9. AGE (In years last birthday) <i>64</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Artist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Commercial</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Elmer E. Jenkins</i>		14. MOTHER'S MAIDEN NAME <i>Easton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>WW I</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Monne Jenkins</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive C-V Disease</i> DUE TO (c) <i>4+ yrs</i>			INTERVAL BETWEEN ONSET AND DEATH <i>20 min</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Emphysema</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/30</i> , 19 <i>52</i> , to <i>6/3</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6/3</i> , 19 <i>57</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Kurt F. King</i>		ADDRESS (Street, city, or town, state) <i>715 Frederick Rd. Balto 28 Md 6469</i> DATE SIGNED <i>6/4/59</i>	
PHYSICIAN'S NAME (Type) <i>Mal Mabb &amp; Son</i>		ADDRESS <i>28</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/6/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. Co. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mal Mabb &amp; Son</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Knecht</i> 24b. REGISTRAR'S SIGNATURE	
DATE <i>JUN 8 '59</i>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6398 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06459

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TURNER'S STATION</b>		c. LENGTH OF STAY IN 1b <b>20 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TURNER'S STATION</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>121 BARBERRY CT.</b>				d. STREET ADDRESS <b>121 BARBERRY CT.</b>			
3. NAME OF DECEASED (Type or print) <b>EIVA E. JORDAN</b>				4. DATE OF DEATH <b>JUNE 23 1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/16/05</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ANNE ARUNDEL Co. Md.</b>	
13. FATHER'S NAME <b>Ellsworth GREEN</b>				14. MOTHER'S MAIDEN NAME <b>EMMA JOHNSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO.			
				17. INFORMANT <b>Mrs. CHAVIS - 722 VANDEYETE AVE.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cornay Occlusion</b> <b>420.1</b> DUE TO (b) <b>A-S-C-V Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH —
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M. B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/24/59</b>			
EXAMINER'S NAME (Type) <b>M. B. DAVIS MD</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-26-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PARK</b>		22d. LOCATION (City, town, or county) (State) <b>Arbutus Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Milton E. Clickner</b>				24a. REC'D BY REGISTRAR <b>JUN 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>8-26-27</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		OCCUPATION <i>Teacher</i>	
RESIDENCE <i>123 Main St, Baltimore, Md</i>		PLACE OF DEATH <i>Home</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF EXAMINER <i>Dr. J. Smith</i>		DATE <i>8-27-27</i>	
LOCAL HEALTH OFFICER <i>John Doe</i>		DATE <i>8-27-27</i>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT. IT IS NOT VALID FOR OTHER PURPOSES.

1  
Page 4  
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 June 1959										
6470 CERTIFICATE OF DEATH										
Reg. Dist. No. 05276										
1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4					
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>House in Pines</u>					d. STREET ADDRESS <u>4112 Groveland Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>LENA</u> First <u>KADISH</u> Middle Last					4. DATE OF DEATH <u>JUNE</u> Month <u>2-</u> Day <u>1959</u> Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>— 1984</u>		9. AGE (In years last birthday) <u>75</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles SAVAGE</u>					14. MOTHER'S MAIDEN NAME <u>Not known</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>					16. SOCIAL SECURITY NO.		INFORMANT Address <u>ROBERT KADISH, 4112 GROVELAND AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung cancer - 12 yrs. (4 Pneumonia) complicated</u> 260X DUE TO <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized atherosclerosis</u> DUE TO <u>Post-operative - (aspirated food material - for gastro)</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>few weeks</u> <u>May 11 - 1959</u>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug.</u> 1959, to <u>June 2</u> , 1959, that I lost saw the deceased alive on <u>June 1</u> , 1959, and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baltimore, Md</u> DATE SIGNED <u>6/3/59</u> ACTUAL SIGNATURE <u>Bernard J. Cohen</u> M.D. <u>The Marylander</u> PHYSICIAN'S NAME (Type) <u>Baltimore</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u> ADDRESS <u>2100 Eutaw Place</u>					24a. REC'D BY REGISTRAR DATE <u>JUN 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Knaub</u>			

1

06460

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>40yr2mth12dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		<b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1602 Ellamont Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth</b>		First Middle Last <b>Elizabeth Kahl</b>		4. DATE OF DEATH Month Day Year <b>June 12 19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 17, 1878</b>	
9. AGE (In years last birthday) <b>81</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>12 19 59</b>		11. IF UNDER 24 HRS. Months Days Hours Min. <b>12 19 59</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Kahl</b>		14. MOTHER'S MAIDEN NAME <b>Christina Wiess</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 20</b> , 19 <b>59</b> , to <b>June 12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 12, 1959</b> , and that death occurred at <b>6:45a</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Stella Wachsler</b>		DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-12-59</b>			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D. <b>Stella Wachsler, M. D.</b>		Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-15-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Howard Strong</b>		ADDRESS <b>3207 W North Ave</b>		24a. REC'D BY REGISTRAR <b>June 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

100000

NAVY AND STATE DEPARTMENT OF HEALTH - BASTINORE, 18

CERTIFICATE OF DEATH

100000

DEATH CERTIFICATE  
JAN 10 1900  
100000

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Place of death		6. Cause of death		7. Signature of physician		8. Signature of registrar	
JAMES B. BROWN		Male		35		Jan 10 1900		New York City		Heart Disease		[Signature]		[Signature]	
9. Occupation		10. Marital status		11. Education		12. Religion		13. Birth date		14. Birth place		15. Date of burial		16. Place of burial	
Teacher		Married		High School		Catholic		Jan 1 1865		New York City		Jan 15 1900		New York City	
17. Name of informant		18. Address of informant		19. Signature of informant		20. Date of report		21. Name of registrar		22. Address of registrar		23. Signature of registrar		24. Date of filing	
John B. Brown		123 Main St		[Signature]		Jan 12 1900		John B. Brown		123 Main St		[Signature]		Jan 12 1900	

DEATH CERTIFICATE  
JAN 10 1900  
100000

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06461

6472

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>B</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>28yr6mtn23dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>(Nettie)</b> Middle <b>Mary A.</b> Last <b>Keagle</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1877</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>seamstresses</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
13. FATHER'S NAME <b>Henry H. Keagle</b>		14. MOTHER'S MAIDEN NAME <b>Isabell Hanson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 29, 1959</b> , to <b>June 30, 1959</b> , that I last saw the deceased alive on <b>June 30, 1959</b> , and that death occurred at <b>10:00p</b> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.		<b>SPRING GROVE STATE HOSPITAL 7-1-59</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-3-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John C. Miller Inc.-2431-35</b>		ADDRESS <b>E. Oliver St.</b>	
24a. REC'D BY REGISTRAR <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6473

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b> <b>3Y01-4</b>	
3. NAME OF DECEASED (Type or print) <b>Philip E. Kerns Sr.</b>		4. DATE OF DEATH <b>June 2, 1959</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1891</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mechanic, Glen L. Martin Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward D. Kerns</b>		14. MOTHER'S MAIDEN NAME <b>Laura M. Vogelsang</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-18-3147</b>	
17. INFORMANT <b>Mr. Philip E. Kerns Jr.</b>		18. ADDRESS <b>1241 Via Del Mar-Winter Park Fla.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>236X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephritis chronic</b> DUE TO (c) <b>Tumor, undiagnosed, rt. Kidney</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>6 mo.</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteoarthritis, generalized, severe.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-1</b> , 19 <b>57</b> , to <b>June 2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 2</b> , 19 <b>59</b> , and that death occurred at <b>12:25 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John F. Schaefer</b> M.D.		DATE SIGNED <b>6/4/59</b>	
PHYSICIAN'S NAME (Type) <b>JOHN F. SCHAEFER</b>		ADDRESS (Street, city or town, state) <b>Balto. 29 Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/5/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir.</b>		24a. REC'D BY REGISTRAR <b>JUN 5 '59</b>	
ADDRESS <b>4101 Edmondson Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00482

CERTIFICATE OF DEATH

6213

MD.

Baltimore

Balto.

Catonsville

419 Maryland St

Highway Manor

John Br.

Philip

April 10, 1951

M. W.

Medical Records, John D. Martin Co.

James W. Vorseburg

Edward J. Korne

215-12-5127 Mr. Philip J. Korne Jr. 1111 1st Ave N.E.  
Walter Park, Md.

3/20/51  
Wm  
1/2/51

*Handwritten notes:*  
Chronic  
Hypertension  
Coronary artery disease  
Myocardial infarction  
Atherosclerosis

*Handwritten notes:*  
3/20/51  
Wm  
1/2/51

*Handwritten notes:*  
3/20/51  
Wm  
1/2/51

Balto, Md.

New Catholic Cem.

3/20/51

Gravestone

Wicks Funeral Dir. 4101 Amsterdam Ave

6474

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ABINGDON</b>	
c. LENGTH OF STAY IN 1b <b>12 DAYS</b>		d. STREET ADDRESS <b>12X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALLEN</b> Middle <b>S</b> Last <b>KIRKWOOD</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 21, 1891</b>
9. AGE (In years last birthday) yrs. <b>68</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GRAIN INSPECTOR (RETIRED) U.S. DEPT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>	
11. BIRTHPLACE (State or foreign country) <b>JARRETTVILLE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWIN C. KIRKWOOD</b>		14. MOTHER'S MAIDEN NAME <b>MARY BELL BEVARD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW-1</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>CLIN REC VET ADM HOSP FORT HOWARD MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>420.0</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS; CHRONIC BRAIN SYNDROME; ARTERIOSCLEROSIS</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 21. I certify that I attended the deceased from <b>May 29, 19 59</b> , to <b>June 10, 19 59</b> , that I last saw the deceased alive on <b>June 10, 19 59</b> , and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6-10-59</b> ACTUAL SIGNATURE <b>Walter J. Pijanowski</b> M.D. <b>WALTER J. PIJANOWSKI, M.D.</b> (MADONNA) PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>June 13, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BETHEL PRESBYTERIAN CHURCH</b>		22d. LOCATION (City, town, or county) (State) <b>HARFORD COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H K McComas</b>		ADDRESS <b>Abingdon, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JUN 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6475

## CERTIFICATE OF DEATH

06464

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison, Md.</u>		c. LENGTH OF STAY IN 1b <u>60 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Foxleigh-Garrison, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sarah</u>		4. DATE OF DEATH <u>June 10 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years lost birthday) <u>69</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Max Friedlander</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Cohen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.1</u> <u>Brainoma of transverse colon</u> DUE TO (b) <u>with abdominal metastases</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>Present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8 June</u> , 19 <u>59</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul H Royse</u> M.D.		ADDRESS (Street, city or town, state) <u>808 Reisterstown Rd, Pikesville 8 Md.</u>	
PHYSICIAN'S NAME (Type) <u>PAUL H ROYSE MD.</u>		DATE SIGNED <u>June 8 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Euston Place</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 11 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06465

## 6476 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Reisterstown</u>		LENGTH OF STAY (in this place) <u>81 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Berryman's Lane</u>				STREET ADDRESS (If rural give location) <u>Berryman's Lane</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Frederick</u> (Middle) <u>William</u> (Last) <u>Korman</u>				(Month) <u>June</u> (Day) <u>21</u> (Year) <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Nov 29 1877</u>	9. AGE last birthday <u>81 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Korman</u>				14. MOTHER'S MAIDEN NAME <u>Christine Wallace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>George W Korman Reisterstown Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>30 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic C-V Disease</u>						<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION <u>no</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u>none</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>none</u>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>12-3-44</u> , 19....., to <u>6-21-59</u> , 19....., that I last saw the deceased alive on <u>6-17-59</u> , 19....., and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>D. D. Capler</u>				ADDRESS (Street, city, town, state) <u>M.D. 6 Hanover Rd., Reisterstown, Md.</u>			
DATE SIGNED <u>6-23-59</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 24 1959</u>		NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>		LOCATION (City, town, or county) (State) <u>Reisterstown Md</u>	
24. REC'D BY REGISTRAR DATE <u>JUN 25 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur L. Hana</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mr Berryman + Sons</u>			



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6477

CERTIFICATE OF DEATH

06466

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KINGSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KINGSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BRADSHAW RD</u>				d. STREET ADDRESS <u>13 BRADSHAW RD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Conrad</u> Middle <u>Lauterbach</u> Last <u>Lauterbach</u>				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 6-1863</u>	
9. AGE (In years lost birthday) <u>96</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FURNITURE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>CONRAD LAUTERBACH</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS GARDNER HALL - 502 HATHERLEIGH</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO <u>left hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28, 1959</u> , to <u>June 28, 1959</u> , that I last saw the deceased alive on <u>June 28, 1959</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>6-30-59</u>			
PHYSICIAN'S NAME (Type) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEM</u>		22d. LOCATION (City, town, or county) (State) <u>PARKVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM FUNERAL HOME 4210 BELAIR</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6478**  
**CERTIFICATE OF DEATH**

06467

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>52 Catonsville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b> d. STREET ADDRESS <b>613 Plymouth Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ISABELLE BAYLY LEFRANC</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1870</b>
9. AGE (In years lost birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>---</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>---</b>	
13. FATHER'S NAME <b>Wm. L. Bayly</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Wales</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Miss Amelie Louise Lefranc-619 Plymouth Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis &amp; occlusion</b> <b>420.1</b> DUE TO <b>Advanced arteriosclerosis &amp; hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular disease</b> DUE TO (c) <b>---</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 Jan</b> , 19 <b>58</b> to <b>29 June</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>29 June</b> , 19 <b>59</b> , and that death occurred at <b>5 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>601 Wmms Ave</b> DATE SIGNED <b>30 June 59</b> ACTUAL SIGNATURE <b>Emil H. Hennig Jr</b> PHYSICIAN'S NAME (Type) <b>EMIL H HENNING JR MD Balto 29 Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/1/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto</b> <b>17 Md</b>		24a. REC'D BY REGISTRAR <b>DATE 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Fenn</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 10

11

DATE OF DEATH

PLACE

DATE OF BIRTH

PLACE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6479  
CERTIFICATE OF DEATH

06468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>52</b> Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		d. STREET ADDRESS <b>1 270 Blakeney Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>VIRGINIA</b> Last <b>LLORENS</b>		4. DATE OF DEATH Month <b>June 27,</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. <del>PREVIOUS MARRIAGE</del> WIDOWED <input checked="" type="checkbox"/> <del>WIDOWED</del>	8. DATE OF BIRTH <b>June 1, 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert Richardson</b>		14. MOTHER'S MAIDEN NAME <b>Sarah</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Marian Kelly - 270 Blakeney Rd., Catonsville</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>154x</b> DUE TO Coronary Thrombosis Auricular Fibrillation Anular carcinoma of rectum with metastasis to bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 months</b> <b>1 yr.?</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5.7</b> , 19 <b>58</b> to <b>6.27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6.27</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>805 Frederick Ave 28 Md</b> DATE SIGNED <b>6.4/59</b> ACTUAL SIGNATURE <b>George E. Urban M.D.</b> PHYSICIAN'S NAME (Type) <b>George E. URBAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Louder Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Pickner &amp; Sons - Balto</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 1 '59</b>	
ADDRESS <b>17 Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	



6480

CERTIFICATE OF DEATH

06469

Reg. Dist. No.

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>First Baptist Congregation</u>				d. STREET ADDRESS <u>7105 Bofford Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>A.</u> Last <u>LOSOVER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
INFORMANT Address <u>Mrs. Freda Snider - 7105 Bofford Rd.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Hypertensive C.V. D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Coronary occlusion</u> DUE TO <u>5 yr.</u> (c) <u>Peripheral vascular disease</u> DUE TO <u>7 yr.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yr.</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yr.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1951</u> to <u>Jan 24 1959</u> that I last saw the deceased alive on <u>Jan 24 1959</u> and that death occurred at <u>91 M</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph B. Gross</u> M.D.				DATE SIGNED <u>Jan 21 1959</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH B. GROSS</u>				ADDRESS (Street, city or town, state) <u>6911 Park Heights Ave</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 30/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Worship Circle</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Lawrence &amp; Sons Inc.</u> ADDRESS <u>1124-26 W. Mt. Airy</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur A. Thana</u>			

0830

CERTIFICATE OF DEATH

08400



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6481

## CERTIFICATE OF DEATH

06470

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	c. LENGTH OF STAY IN 1b <b>3 YEARS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RIDGEWAY MANOR NURSING HOME</b>		e. STREET ADDRESS <b>1 510 WILSON AVENUE</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARIA J. LUOTO</b>		4. DATE OF DEATH Month Day Year <b>JUNE 19, 1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 22, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (State or foreign country) <b>FINLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>UNKNOWN</b>	
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. ANDY LUOTO</b> Address <b>510 WILSON AVE, BALTO 24</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Cerebral artery disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral artery sclerosis</b> DUE TO <b>10 days</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. n. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>APRIL 16, 1959</b> , to <b>JUNE 19, 1959</b> , that I last saw the deceased alive on <b>JUNE 16, 1959</b> , and that death occurred at <b>1:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6-19-59</b> ACTUAL SIGNATURE <b>J. Nelson M. Key</b> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JUNE 21, 59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC.</b> <b>BALTIMORE 13, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>JUN 22 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Clarence J. K...</b>



TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6482

## CERTIFICATE OF DEATH

06471

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 Hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>3034 Matthews Street</b>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>C.</b> Last <b>MANNING</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 November 16, 1891</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service Elevators</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Manning</b>		14. MOTHER'S MAIDEN NAME <b>Clara Healy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>214-03-0391</b>	
17. INFORMANT <b>Clin. Rec., Vet. Administration Hospital, Ft. Howard</b>		Address <b>Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MYOCARDIAL INFARCTION, OLD</b> DUE TO (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4:15 PM 6/25 19 59</b> to <b>5:45 PM 6/25 59</b> and that death occurred at <b>5:45 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>6/26/59</b>	
ACTUAL SIGNATURE <b>Donald D. Mark</b>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK</b>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/29/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek Funeral Home, Balto. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6483

## CERTIFICATE OF DEATH

06472

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b <b>35 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6719 Roberts Avenue</b>		d. STREET ADDRESS <b>6719 Roberts Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>UN.</b> Last <b>Martin</b>		4. DATE OF DEATH Month <b>6</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-16-1877</b>
9. AGE (In years last birthday) <b>81 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rubberoid Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Europe</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UN. Martin</b>		14. MOTHER'S MAIDEN NAME <b>UN.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-18-9504</b>	
17. INFORMANT <b>Alice Listopad - 6719 Roberts Ave. #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic C.V. Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 Mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> 19 <b>59</b> , to <b>June 28, 1959</b> , that I last saw the deceased alive on <b>June 27, 1959</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen C. Mackowiak M.D.</b>		ADDRESS (Street, city or town, state) <b>6714 Holabrook Ave</b>	
PHYSICIAN'S NAME (Type) <b>S. C. MACKOWIAK</b>		DATE SIGNED <b>6-29-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-30-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Trinity Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Dabrowski</b>		ADDRESS <b>1001A - Dundalk Ave</b>	
24a. REC'D BY REGISTRAR <b>JUL 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6484

## CERTIFICATE OF DEATH

06473

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Monkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural - Monkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Houck Mill Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dorothy Marie Mays</u>				4. DATE OF DEATH <u>June 17, 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24 1910</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Corbett, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Ingie</u>				14. MOTHER'S MAIDEN NAME <u>Mary Burton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Hypertension</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/26</u> , 19 <u>59</u> to <u>6/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/17</u> , 19 <u>59</u> , and that death occurred at <u>11:00 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				ADDRESS (Street, city or town, state) <u>PARKTON, Md.</u>		DATE SIGNED <u>6/19/59</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 20, 1959</u>		<u>Heretford Baptist Cem.</u>		<u>Heretford, Balto. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Kurlenstein</u> ADDRESS <u>New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>JUN 23 '59</u>		<u>Arthur L. Kinner</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6402

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1320 Poplar Ave.</u>		d. STREET ADDRESS <u>1320 Poplar Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Nathan A McCall</u>		4. DATE OF DEATH <u>June 10</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. R. R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>717-67-6916</u>	
17. INFORMANT <u>Sarah J McCall</u>		Address <u>1320 Poplar Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/14</u> , 19 <u>58</u> to <u>13 JUNE 1959</u> , that I last saw the deceased alive on <u>13 JUNE</u> , 19 <u>59</u> , and that death occurred at <u>7:40 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George E. Gorman</u> M.D.		ADDRESS (Street, city or town, state) <u>main St. Elmdale 27, Md.</u> DATE SIGNED <u>15 June 59</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/17/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Embrose, Inc. 1324 Sulphur Spring Rd.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 16 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR TO FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

10-1-33

CERTIFICATE OF DEATH

0303

NAME OF DECEASED		DATE OF BIRTH	
SEX		RACE	
MARRIAGE		OCCUPATION	
EDUCATION		RELIGION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE OR INJURY		MEDICAL ATTENDANCE	
PREVIOUS ILLNESS		TREATMENT	
HISTORY OF PRESENT ILLNESS		FAMILY HISTORY	
SOCIAL HISTORY		HISTORICAL DATA	
LABORATORY DATA		PATHOLOGICAL DATA	
RADIOLOGICAL DATA		OTHER DATA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE HEALTH COMMISSIONER, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6485

## CERTIFICATE OF DEATH

06475

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>		c. LENGTH OF STAY IN 1b <b>X</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8401 Courtleigh Rd.</b>		d. STREET ADDRESS <b>8401 Courtleigh Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>McDERMOTT</b> Last <b>McDERMOTT</b>		4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1865</b>
9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR: Months <b>6</b> Days <b>11</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Martin Schanze</b>		14. MOTHER'S MAIDEN NAME <b>? (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Edward M. McDermott - 8401 Courtleigh Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio - Rerul Vascular Disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 12</b> , 19 <b>58</b> , to <b>June 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 8</b> , 19 <b>59</b> , and that death occurred at <b>9 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George E. Shannon</b>		ADDRESS (Street, city or town, state) <b>820 Medical Arts Building</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>George E. Shannon M.D.</b>		<b>Baltimore 1</b> <b>md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. J. S. Sicker &amp; Sons - Baltore</b>		ADDRESS <b>Md</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur P. K...</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6486

CERTIFICATE OF DEATH

06476

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>2 Yrs. 12 Das.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Sheppard and Enoch Pratt Hospital</b>				d. STREET ADDRESS <b>3701 Jocelyn Street, N. W.</b>			
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Chamberlain</b> Last <b>McEntee</b>				4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 17, 1876</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>				13. FATHER'S NAME <b>Samuel S. Chamberlain</b>			
14. MOTHER'S MAIDEN NAME <b>May Taylor Munson</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia, bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis, senile brain disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>May 30, 1957</b> , to <b>June 12, 1959</b> , that I last saw the deceased alive on <b>June 11, 1959</b> , and the death occurred at <b>11:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sheppard Pratt Hosp. June 12, 1959</b> DATE SIGNED ACTUAL SIGNATURE <b>W.W. Elgin</b> M.D. <b>Towson - 4, Maryland</b> PHYSICIAN'S NAME (Type) <b>W.W. Elgin</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>6/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL, CREMATORY</b>		22d. LOCATION (City, town, or county) (State) <b>SUITLAND, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Hawley's Sons</b>				ADDRESS <b>1756 Pa. Ave., N.W. DC</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 15 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1938

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		65		1873	
RESIDENCE		PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH	
1234 Main St., Baltimore, Md.		Maryland		Carpenter		Heart Disease	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE	
Jan 15, 1938		Baltimore, Md.		10:30 AM		Normal	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE		TIME	
J. H. Harris		J. H. Harris		Jan 15, 1938		10:30 AM	
TESTIFYING PHYSICIAN		TESTIFYING SURGEON		DATE		TIME	
J. H. Harris		J. H. Harris		Jan 15, 1938		10:30 AM	

1

1938

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06477

6487

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>43 Selridge Rd</u>		d. STREET ADDRESS <u>143 Selridge Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Delta</u> Middle <u>M</u> Last <u>Meadows</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec 8 1920</u>
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chas Peary</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Glass</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>224-16-1165</u>	
17. INFORMANT <u>James Peary</u>		Address <u>3219 E Joppa Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CA Female Pericarditis</u> <u>176.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-2</u> , 19 <u>58</u> , to <u>6-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-26</u> , 19 <u>59</u> , and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marvin Rombro</u>		ADDRESS (Street, city or town, state) <u>805 Furlong Ave Baltimore, Md</u>	
PHYSICIAN'S NAME (Type) <u>MARVIN ROMBRO</u>		DATE SIGNED <u>6-26-59</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>June 29-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CORNER HILL</u>		22d. LOCATION (City, town, or county) (State) <u>AA Co MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS. F. EVANS &amp; Son</u>		ADDRESS <u>8802 HARTFORD RD</u>	
24a. REC'D BY REGISTRAR <u>JUL 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1987

1987

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		White		1/1/1920		1/15/1987		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Date of funeral		12. Name of funeral home		13. Name of cemetery		14. Name of burial place		15. Name of officiating clergyman		16. Name of officiating minister		17. Name of officiating priest		18. Name of officiating rabbi		19. Name of officiating imam		20. Name of officiating cantor	
1/20/1987		ABC Funeral Home		Greenwood Cemetery		Section 1, Lot 10		Rev. John Smith		Rev. John Smith		Rev. John Smith		Rev. John Smith		Rev. John Smith		Rev. John Smith	
21. Name of informant		22. Address of informant		23. Telephone number of informant		24. Name of informant		25. Address of informant		26. Telephone number of informant		27. Name of informant		28. Address of informant		29. Telephone number of informant		30. Name of informant	
John Doe		123 Main St		555-1234		John Doe		123 Main St		555-1234		John Doe		123 Main St		555-1234		John Doe	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6488 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06478

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>55</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b> d. STREET ADDRESS <b>509 Yarmouth Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>CLARENCE EDWARD MEDINGER</b> First Middle Last 4. DATE OF DEATH <b>June 18, 1959</b> Month Day Year			5. SEX <b>male</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <b>Oct. 11, 1877</b> 9. AGE (In years last birthday) <b>81 yrs.</b> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired (Salesman)</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Tea</b> 11. BIRTHPLACE (State or foreign country) <b>Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>Md.</b>			13. FATHER'S NAME <b>Henry Medinger</b> 14. MOTHER'S MAIDEN NAME <b>Mamie Willis</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> 16. SOCIAL SECURITY NO. <b>216-07-8685</b> 17. INFORMANT <b>Mr. Irwin D. Medinger - 509 Yarmouth Rd.</b> Address			18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Decompensation</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>12 Hrs.</b>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles F O'Donnell</b> EXAMINER'S NAME (Type) <b>Charles F O'Donnell</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>6/20/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Balto. Cem.</b> 22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto</b> ADDRESS <b>17 Md</b> 24a. REC'D BY REGISTRAR <b>JUN 22 '59</b> 24b. REGISTRAR'S SIGNATURE <b>C. L. Kraus</b>		

MEDICAL CERTIFICATION



DATE OF BIRTH

SEX

ETHNIC ORIGIN

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF EXHUMATION

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PLACE OF REINTERMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06479

6489

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>601 Laurel Hill Lane</b>		d. STREET ADDRESS <b>601 Laurel Hill Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>GEORGE</b> Last <b>MENZEL</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16,</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 26, 1898</b>
9. AGE (In years lost birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Behrend Bros.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Oscar Menzel</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Eichelbeck</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or date of service) <b>World War I</b>		16. SOCIAL SECURITY NO. <b>216-09-8408</b>	
17. INFORMANT <b>Mrs. B. Ruth Menzel - 601 Laurel Hill Lane</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>6 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug.</b> , 19 <b>47</b> , to <b>June</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 27</b> , 19 <b>59</b> , and that death occurred at <b>5:00PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1 Mallow Hill Ave., Baltimore 29, Md.</b> DATE SIGNED <b>6/17/59</b>			
ACTUAL SIGNATURE <b>Leo J. Gaver</b>		M.D. <b>1 Mallow Hill Ave., Baltimore 29, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Leo J. Gaver, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickner &amp; Sons - Balto 17</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 18 '59</b>	
ADDRESS <b>mid</b>		24b. REGISTRAR'S SIGNATURE <b>Clairmont L. Howard</b>	

CERTIFICATE OF DEATH

6489

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH April 15, 1944		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. MEDICAL HISTORY Hypertension, Atherosclerosis	
10. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		11. SIGNATURE OF WITNESSES J. H. Smith, M.D. J. H. Smith, M.D.		12. SIGNATURE OF REGISTRAR J. H. Smith, M.D.	
13. PLACE OF BIRTH Baltimore, Md.		14. DATE OF BIRTH April 15, 1879		15. OCCUPATION Teacher	
16. MARITAL STATUS Married		17. EDUCATION High School		18. RELIGION Roman Catholic	
19. PREVIOUS ILLNESSES Hypertension, Atherosclerosis		20. MEDICATIONS None		21. ALCOHOLIC BEVERAGES None	
22. TOBACCO None		23. DRUGS None		24. OTHER None	
25. SIGNATURE OF DECEASED None		26. SIGNATURE OF NEXT OF KIN None		27. SIGNATURE OF BURIAL OFFICER None	
28. SIGNATURE OF INTERVIEWER None		29. SIGNATURE OF REGISTRAR None		30. SIGNATURE OF PHYSICIAN None	

1

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. AND A COPY IS TO BE FURNISHED TO THE BUREAU OF VITAL STATISTICS, BALTIMORE, MD. AND TO THE BUREAU OF VITAL STATISTICS, WASHINGTON, D.C.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06480

6490

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville 39</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>15205 Garmouth</b>			
3. NAME OF DECEASED (Type or print) First <b>Oscar</b> Middle <b>Sidney</b> Last <b>Millman</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-6-1892</b>		9. AGE (In years last birthday) <b>67 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Supt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stock yards</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Myer Millman</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Abell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-0347</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>7-17-1958</b> to <b>6-20-1959</b> , that I last saw the deceased alive on <b>June 19, 1959</b> , and that death occurred at <b>6:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b>				M.D. <b>Mt. Wilson, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>				Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-23-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Forley Funeral Home - Catonsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06481

6491

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (17)</b> <b>3V01-4</b>	
f. STREET ADDRESS <b>1706 Fulton Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MANN</b> Middle <b>---</b> Last <b>MOODY</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1, 1890</b>
9. AGE (In years last birthday) <b>69 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Middlesex Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carty Moody</b>		14. MOTHER'S MAIDEN NAME <b>Louise Gresson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>212-14-2328</b>	
17. INFORMANT <b>Clinical Rec. VA Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF HEAD OF PANCREAS WITH OBSTRUCTIVE</b> <b>157X</b> <b>XXXX JAUNDICE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>June 12</b> , 19 <b>59</b> , to <b>June 17</b> , 19 <b>59</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA Hospital, Ft. Howard, Md. 6/18/59</b> ACTUAL SIGNATURE <b>John W. Crawford</b> M.D. <b>VA Hospital, Ft. Howard, Md. 6/18/59</b> PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VA Hospital, Ft. Howard, Md. 6/18/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-22-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem. Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ARRINGTON S. PHILLIPS</b> ADDRESS <b>1808-10 N. Monroe St. Baltimore 17, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 24 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kruza</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 1 090 1 VS A15 (4) ISM 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 6492 06482 Reg. Dist. No. 1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ 3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year 5. SEX 6. COLOR OR RACE 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH 9. AGE (In years last birthday) yrs. Months Days Hours Min 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage & paralysis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-vascular disease DUE TO (c) \_\_\_\_\_ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) \_\_\_\_\_ 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 20d. INJURY OCCURRED While ☐ Not-while ☐ of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Oct 22, 1958, to June 20, 1959, that I last saw the deceased alive on June 17, 1959, and that death occurred at P. P. M. from the causes and on the date stated above. ACTUAL SIGNATURE Halter S. Tibbitt M.D. ADDRESS (Street, city or town, state) DATE SIGNED 4408 Loch Raven Blvd PHYSICIAN'S NAME (Type) Halter S. Tibbitt 4408 Loch Raven Blvd 22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

## 6492 06482 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Conv. Home</u>				d. STREET ADDRESS <u>4214 Belmar Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leila F. Morris</u>				4. DATE OF DEATH Month Day Year <u>June 20, 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 16, 1892</u>	
9. AGE (In years last birthday) yrs. <u>66</u>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comptometer Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Chance, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Gustavus B. James</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-18-5704</u>		17. INFORMANT Address <u>Mr. Henry W. Morris 4214 Belmar Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage &amp; paralysis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-vascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>							
20d. INJURY OCCURRED While <input type="checkbox"/> Not-while <input type="checkbox"/> of work of work							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 22</u> , 19 <u>58</u> , to <u>June 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 17</u> , 19 <u>59</u> , and that death occurred at <u>P. P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Halter S. Tibbitt</u> M.D. ADDRESS (Street, city or town, state) DATE SIGNED <u>4408 Loch Raven Blvd</u>							
PHYSICIAN'S NAME (Type) <u>Halter S. Tibbitt</u> <u>4408 Loch Raven Blvd</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 23, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Lassahn Funeral Home 7401 Belair Rd.</u>							
24a. REC'D BY REGISTRAR DATE <u>JUN 24 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

10488

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

6498

RECEIVED FROM B. J. ...

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		1918-01-15		1963-03-10		Home		Heart Disease		[Signature]		[Signature]	
Occupation		Education		Marital Status		Religion		Usual Residence		Place of Burial		Time of Death		Manner of Death		Certified True and Correct		Date	
Teacher		High School		Married		Catholic		123 Main St, Baltimore, MD		Catholic Cemetery		10:00 AM		Natural		[Signature]		1963-03-11	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06483

6493

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore,</b> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>301 W. Chesapeake Ave. (Home)</b>		d. STREET ADDRESS <b>119 Hawthorne Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rowena</b> Middle <b>West</b> Last <b>Naylor</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28,</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 13, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Christopher West</b>		14. MOTHER'S MAIDEN NAME <b>Dorcas Rowena Caughy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Lawrence Naylor</b> Address <b>109 Churchwardens Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493X DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Paralysis agitans</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>? yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paralysis agitans</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/22/59</b> to <b>6/28/59</b> , 19____, that I last saw the deceased alive on <b>6/22/59</b> , 19____, and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Francis W. Gluck</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Francis W. Gluck</b>		<b>100 W. University Parkway</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>July 1, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc. 1900 Eutaw Place</b> ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUL 1 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 6244 7-14-59 et

6494

## CERTIFICATE OF DEATH

Reg. Dist. No.

07651

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Brighton</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 15, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <u>6509 Armstrong Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <u>Jack</u> First <u>Richard</u> Middle <u>Nelson</u> Last			<b>4. DATE OF DEATH</b> <u>June</u> Month <u>29</u> Day <u>19</u> Year <u>59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1885</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. House of Correct</u>		11. BIRTHPLACE (State or foreign country) <u>Red Rock, Texas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Floyd Nelson</u>			14. MOTHER'S MAIDEN NAME <u>Sarah</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>220-07-1239</u>		17. INFORMANT <u>Baltimore 15, Md.</u> <u>Mrs. Emily J. Nelson, 6509 Armstrong Ave.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> (c) <u>Generalized Art. Sclerosis</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>					
19. INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>3 wks.</u> <u>2 yrs.</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 15, 1953</u> to <u>June 29, 1959</u> , that I last saw the deceased alive on <u>June 29, 1959</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>James A. Miller, M.D.</u>		ADDRESS (Street, city or town, state) <u>1331 Reisterstown Rd</u>		DATE SIGNED <u>6/30/59</u>	
PHYSICIAN'S NAME (Type) <u>James A. Miller, M.D.</u> <u>Pikesville 8, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Pikesville 8, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville 8, Md.</u>		24. REC'D BY REGISTRAR <u>DATE JUL 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Newell</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

FILE NO. 100

NAME OF DECEASED		AGE AT DEATH	
SEX		DATE OF BIRTH	
PLACE OF BIRTH		DATE OF DEATH	
CITY		COUNTY	
STATE		COUNTRY	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF DEATH	
EDUCATION		DATE OF INTERMENT	
RELIGION		NAME OF MINISTER	
SIGNED BY		DATE	
TITLE		COUNTY	
STATE		COUNTRY	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06484

6495

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN TB <b>2yr11mth19dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>B.</b> Last <b>Nelson</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1897</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>stenographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>hail road clerk</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Nelson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Tribull</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>705-07-9314</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary abscesses</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Unresolved pneumonia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>weeks?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 6, 19 56</b> , to <b>6/28 59</b> , that I last saw the deceased alive on <b>6/28 59</b> , and that death occurred at <b>2:55 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslor</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b>		Catonsville 28, Maryland <b>6/28/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>6/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto</b>		24a. REC'D BY REGISTRAR <b>JUL 1 59</b>	
ADDRESS <b>17th</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

00101

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

CERTIFICATE OF DEATH

6688

DATE OF DEATH

PLACE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

1

Form with multiple lines for text entry, including fields for date, place, and other details. The text is mostly illegible due to the quality of the scan.

Form with multiple lines for text entry, including fields for date, place, and other details. The text is mostly illegible due to the quality of the scan.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film 6243 6-9-59 et

06485

6496

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>52</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>40 Maple Drive</i>		d. STREET ADDRESS <i>40 Maple Drive</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Antonia</i> First <i>Neufeld</i> Middle Last		4. DATE OF DEATH Month <i>6-</i> Day <i>4-</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>80</i> yrs.
9. AGE (In years less birthday) <i>80</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Poland</i>	
13. FATHER'S NAME <i>Adolph Kugel</i>		14. MOTHER'S MAIDEN NAME <i>Julia Chassel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>Dr. Stella Nachster - Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Cardio-Respiratory failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Myocardial Degeneration</i> (c) <i>Coronary Insufficiency &amp; Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May</i> 19 <i>9/57</i> <i>58</i> , that I last saw the deceased alive on <i>4 June</i> 19 <i>59</i> , and that death occurred at <i>7:15 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William J. Bryson M.D.</i>		ADDRESS (Street, city or town, state) <i>4615 Edmondeston and 4 June</i>	
PHYSICIAN'S NAME (Type) <i>William J. Bryson</i>		DATE SIGNED <i>Balto 29, md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-5-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Chavars chesed</i>		22d. LOCATION (City, town, or county) (State) <i>Randelstown Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc</i>		ADDRESS <i>2100 Eutan Pl</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	
DATE <i>JUN 5 '59</i>			

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100-100000

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

6897

100-100000

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100-100000

6498

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2yr6mth27dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Maude</b> Last <b>Norris</b>				4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1868</b>		9. AGE (In years last birthday) <b>90</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Eliza T. Parks</b>				14. MOTHER'S MAIDEN NAME <b>Anna Tacord</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 26</b> , 19 <b>59</b> , to <b>June 4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 4</b> , 19 <b>59</b> , and that death occurred at <b>3:35</b> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>6-4-59</b>							
ACTUAL SIGNATURE <b>Bruno Radauskas</b>				PHYSICIAN'S NAME (Type) <b>Bruno Radauskas, M. D.</b>			
22a. BURIAL/CREMATION REMOVAL (Specify) <b>burial June 6, 1959</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Vermon Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>White Hall Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank D. Heneel</b>				24a. REC'D BY REGISTRAR <b>June 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6499

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Baltimore</u>		MARYLAND		o. STATE <u>Maryland</u>		b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Md.</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Magnolia, Maryland</u>		<u>12X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>Dembytown Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gladys</u> Middle <u>Viola</u> Last <u>Norton</u>				4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-12-52</u>		9. AGE (In years last birthday) <u>7</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Norton</u>				14. MOTHER'S MAIDEN NAME <u>Gladys Estella Toliver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>status epilepticus</u> <u>353.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter W. Rieckert</u>		M.D. <u>Pathologist</u>		ADDRESS (Street, city or town, state) <u>4307 Marlfield Ln</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>P. W. Rieckert</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/15/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>		22d. LOCATION (City, town, or county) (State) <u>Magnolia, Harford, Md.,</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K McCones</u>				ADDRESS <u>ABINGDON, Mo.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 17 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>			

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

1. Name of Deceased: *Blanche C. [illegible]*  
2. Sex: *F*  
3. Date of Birth: *10-10-1892*  
4. Date of Death: *10-10-1968*  
5. Place of Birth: *Worcester, Mass.*  
6. Usual Residence: *Worcester, Mass.*  
7. Cause of Death: *Stroke*  
8. Manner of Death: *Natural*  
9. Signature of Physician: *[illegible]*  
10. Signature of Registrar: *[illegible]*  
11. Date: *10-10-68*

6500

## CERTIFICATE OF DEATH

06489

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b <b>36 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Essex (21)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>606 Franklin Avenue</b>		d. STREET ADDRESS <b>606 Franklin Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>JACOB</b> Last <b>NOZ</b>		4. DATE OF DEATH Month <b>June</b> Day <b>3rd</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 24, 1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Noz</b>		14. MOTHER'S MAIDEN NAME <b>Anna Maria Kurtzberger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>717-07-7233</b>	
17. INFORMANT <b>Mrs. Fannie Noz</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C.V.D., with</b> <b>422.1</b> DUE TO <b>decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>years</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>58</b> , to <b>June 3, 1959</b> , that I last saw the deceased alive on <b>June 3, 1959</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John E. Gessner</b>		ADDRESS (Street, city or town, state) <b>701 Eastern Avenue</b>	
PHYSICIAN'S NAME (Type) <b>John E. Gessner, M.D.</b>		DATE SIGNED <b>6/4/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Matthew's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Water Brooks Bradley, Inc.</b>		ADDRESS <b>Dundalk 22</b>	
24a. REC'D BY REGISTRAR <b>JUN 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krasa</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6501

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3mth6dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3Y01-4</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>456 Furrow Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Orem</u> Last <u>Orem</u>				4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1877</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>82</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Orem</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>213-09-8657</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease with heart failure</u> (c) <u>generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>long standing</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malnutrition</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 9, 1959</u> , to <u>June 28, 1959</u> , that I last saw the deceased alive on <u>June 28, 1959</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>6-29-59</u>							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				M.D. <u>SPRING GROVE STATE HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE SCHWAB FUNERAL HOME</u> <u>James H. Miller</u>				ADDRESS <u>2101 Frederick Ave.</u> <u>Baltimore, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06491

6502

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baynesville</b>				c. LENGTH OF STAY IN 1b <b>6 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8531 Chestnut Oak Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>M. Outland</b> Last				4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>ABOUT 5/25/1894</b>	
9. AGE (In years last birthday) <b>65?</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beautician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Beauty Salon</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore City Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Michael Leonard</b>				14. MOTHER'S MAIDEN NAME <b>(First name unknown) Flaherty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>216-09-0511</b>		17. INFORMANT Address <b>Mr. T. E. Outland, 8531 Chestnut Oak Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost, (b) DUE TO (c) <b>Arterio hypertension</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/15</b> , 19 <b>57</b> , to <b>6/11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/11</b> , 19 <b>59</b> , and that death occurred at <b>11 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward Gordon Grau</b>				ADDRESS (Street, city or town, state) <b>8523 Loch Raven Blvd. Towson 4, Md.</b> DATE SIGNED <b>6/15/59</b>			
PHYSICIAN'S NAME (Type) <b>Edward Gordon Grau, M.D.</b>				ADDRESS <b>8523 Loch Raven Blvd.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery Taylor Ave. Balto. Co. Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>B. Vernon Lemmon, 4611 Park Hgts. Balto. Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 15 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Flaherty</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1925

<p>1. Name of Deceased: <b>Michael J. Howard</b></p>		<p>2. Sex: <b>Male</b></p>	
<p>3. Race: <b>White</b></p>		<p>4. Age: <b>37</b></p>	
<p>5. Date of Birth: <b>April 12, 1888</b></p>		<p>6. Date of Death: <b>April 12, 1925</b></p>	
<p>7. Place of Birth: <b>Baltimore City, Md.</b></p>		<p>8. Usual Residence: <b>Baltimore City, Md.</b></p>	
<p>9. Cause of Death: <b>Heart Disease</b></p>		<p>10. Manner of Death: <b>Natural</b></p>	
<p>11. Signature of Physician: <b>Dr. J. M. Howard</b></p>		<p>12. Signature of Registrar: <b>John Howard</b></p>	
<p>13. Date of Registration: <b>April 15, 1925</b></p>		<p>14. Place of Registration: <b>Baltimore City, Md.</b></p>	

RECEIVED  
BALTIMORE, MD  
APR 15 1925

THIS CERTIFICATE IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, ON APRIL 15, 1925.

6503

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>55</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		d. STREET ADDRESS <b>41 York Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Palmer</b> Last <b>Palmer</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29th</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 3- 1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min. <b>69</b>	IF UNDER 24 HRS. Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min. <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Chicago Ills.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Holmes</b>		14. MOTHER'S MAIDEN NAME <b>Sibey Lovell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Emma Seed</b>		Address <b>41 York Road, Towson</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Art. Occlusion</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2nd and 3rd degree burns of arms, shoulder</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Smoking in bed and set fire to self</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18a)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>5:30</b> Apr <b>30</b> 1959 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Towson, Baltimore, Md.</b>	
21. I certify that I attended the deceased from <b>July 16, 1958</b> , to <b>June 29, 1959</b> , that I last saw the deceased alive on <b>June 19, 1959</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Boylston D. Smith Jr.</b>		DATE SIGNED <b>6900 HARFORD RD.</b>	
PHYSICIAN'S NAME (Type) <b>Boylston D. Smith Jr.</b>		<b>BALTIMORE 14, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 2-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William D. Smith</b>		24a. REC'D BY REGISTRAR <b>2224 N. Charles</b>	24b. REGISTRAR'S SIGNATURE <b>St. JUN 30 '59</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

## CERTIFICATE OF DEATH

1903

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

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PLACE OF BIRTH

John  
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AP 27

AP 27

1903

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06493

6504

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. LENGTH OF STAY IN 1b <b>X</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Balto.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>311 W. Seminary Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <b>311 W. Seminary Ave.</b>					
3. NAME OF DECEASED (Type or print) <b>EMMA GILES PARKER</b>		4. DATE OF DEATH Month <b>June</b>		Day <b>10</b>		Year <b>19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 4, 1882</b>		9. AGE (In years lost birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Edward Walter Giles</b>		14. MOTHER'S MAIDEN NAME <b>Emma S. Hall</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. W. Giles Parker - 311 W. Seminary Ave.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adeno Carcinoma Rt. Kidney</b> <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Balto., Md.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>2/17, 1959</b> to <b>6/10, 1959</b> , that I last saw the deceased alive on <b>6/9, 1959</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>311 W Seminary Ave Lutherville Md 21111</b>		DATE SIGNED <b>6/11/59</b>					
ACTUAL SIGNATURE <b>Bennett A. Stuenkel</b>		M.D. <b>19 W Seminary Ave Lutherville Md</b>							
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>		22d. LOCATION (City, town, or county) <b>Balto., Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto</b>		ADDRESS <b>17 W. Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			

# CERTIFICATE OF DEATH

W. Giles Parker  
717 Little Bldg  
St. Alto. 2, Md.

<p>NAME OF DECEASED</p>		<p>AGE</p>	
<p>SEX</p>		<p>RACE</p>	
<p>DATE OF BIRTH</p>		<p>DATE OF DEATH</p>	
<p>PLACE OF BIRTH</p>		<p>PLACE OF DEATH</p>	
<p>RESIDENCE</p>		<p>CAUSE OF DEATH</p>	
<p>DATE OF INTERMENT</p>		<p>PLACE OF INTERMENT</p>	
<p>NAME OF MINISTER</p>		<p>NAME OF FUNERAL HOME</p>	
<p>NAME OF BURIAL PLACE</p>		<p>NAME OF CEMETERY</p>	
<p>NAME OF CITY</p>		<p>NAME OF COUNTY</p>	
<p>NAME OF STATE</p>		<p>NAME OF DISTRICT</p>	
<p>NAME OF COUNTRY</p>		<p>NAME OF TERRITORY</p>	
<p>NAME OF ISLAND</p>		<p>NAME OF POSSESSION</p>	
<p>NAME OF DEPARTMENT</p>		<p>NAME OF DIVISION</p>	
<p>NAME OF BRANCH</p>		<p>NAME OF SECTION</p>	
<p>NAME OF SUBSECTION</p>		<p>NAME OF DIVISION</p>	
<p>NAME OF CITY</p>		<p>NAME OF COUNTY</p>	
<p>NAME OF STATE</p>		<p>NAME OF DISTRICT</p>	
<p>NAME OF COUNTRY</p>		<p>NAME OF TERRITORY</p>	
<p>NAME OF ISLAND</p>		<p>NAME OF POSSESSION</p>	
<p>NAME OF DEPARTMENT</p>		<p>NAME OF DIVISION</p>	
<p>NAME OF BRANCH</p>		<p>NAME OF SECTION</p>	
<p>NAME OF SUBSECTION</p>		<p>NAME OF DIVISION</p>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06494

## 6505 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>S.</b> Last <b>Pierce</b>		4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>stenographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Office</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>175.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic urethral obstruction</b> DUE TO (c) <b>Cystadenocarcinoma of left ovary with generalized metastasis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 26</b> , 19 <b>59</b> , to <b>June 3</b> , 19 <b>59</b> that I last saw the deceased alive on <b>June 3</b> , 19 <b>59</b> , and that death occurred at <b>2:15p</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-3-59</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>June 5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Fountain Green Harford Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b>		24a. REC'D BY REGISTRAR <b>W. Broadway + Williams St. BEL Air, Maryland</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		DATE <b>JUN 8 '59</b>	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 6506 CERTIFICATE OF DEATH

06495

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenarm</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Rd.</b>				/d. STREET ADDRESS <b>Glenarm Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Charles J. B. Piper</b>				4. DATE OF DEATH Month <b>6-28-59</b> Day <b>19</b> Year <b>19</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-3-1905</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.		IF UNDER 24 HRS. Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>never worked</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Augustus A. Piper</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Monroe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Albert D. Cockey, Fid. Balto. Nat. Bank</b>				Address <b>Cockeysville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Sudden</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 28, 1959</b> to <b>June 28, 1959</b> , that I lost saw the deceased alive on <b>June 28, 1959</b> , and that death occurred at <b>2:19 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Rd</b> DATE SIGNED <b>8/29/59</b>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell MD</b>				PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-1-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Waugh Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Glenarm Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>				ADDRESS <b>Towson 4, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>							

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Brooks Funeral Services, Townshend, Vt.

Funeral 7-1-59

Joseph Webb 0721

Glenham Rd.

WILLIAM J. BROOKS

Funeral Home

Name		Augustus A. Piper		Name		Marie		Honor	
Home		Honor		Home		Honor		Honor	
Date		11-1-1903		Date		11-1-1903		Date	
Age		23		Age		23		Age	
Sex		Male		Sex		Male		Sex	
Race		White		Race		White		Race	
Occupation		Never worked		Occupation		Never worked		Occupation	
Religion		Methodist		Religion		Methodist		Religion	
Address		Glenham Rd.		Address		Glenham Rd.		Address	
City		Glenham		City		Glenham		City	
State		Vt.		State		Vt.		State	
County		Franklin		County		Franklin		County	
Married		Never		Married		Never		Married	
Children		None		Children		None		Children	
Education		High School		Education		High School		Education	
Employment		None		Employment		None		Employment	
Social Security		None		Social Security		None		Social Security	
Insurance		None		Insurance		None		Insurance	
Other		None		Other		None		Other	

1903

## 6507 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>W.</b> Last <b>POWELL</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>20</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 1, 1894</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxicab Driver</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>		11. BIRTHPLACE (State or foreign country) <b>Windham, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John W. Powell</b>				14. MOTHER'S MAIDEN NAME <b>Mariah Rappleyea</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 054-16-0324</b>		17. INFORMANT Address <b>Clinical Rec. VA Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Acute</b> <b>Several Years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that VA attended the deceased from <b>June 13</b> , 19 <b>59</b> , to <b>June 20</b> , 19 <b>59</b> , that I last saw the deceased on <b>June 20, 1959</b> , and that death occurred at <b>8:20 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stephen Toms, M.D.</b>			ADDRESS (Street, city or town, state) <b>VA Hospital, Ft. Howard, Md.</b>			DATE SIGNED <b>6/21/59</b>	
PHYSICIAN'S NAME (Type) <b>STEPHEN TOMS, M.D.</b>			ADDRESS <b>VA Hospital, Ft. Howard, Md.</b>			DATE <b>6/21/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-24-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Md.</b>		22d. LOCATION (City, lawn, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc. 6009 Harford Rd.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kirsch</b>	

WM. COOK-BLIGHT, INC. 6009 HARFORD RD., BALTO. MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Date of Death		Place of Death	
John Doe		Male		45		Jan 1, 1930		Jan 15, 1975		Baltimore, MD	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation		Education	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Teacher		High School	
Place of Death		Residence		Hospital		Nursing Home		Other		Autopsy	
Home		St. Mary's Hospital		N/A		N/A		N/A		N/A	
Physician		Medical Examiner		N/A		N/A		N/A		N/A	
Dr. Smith		Dr. Jones		N/A		N/A		N/A		N/A	
Signature		Signature		Signature		Signature		Signature		Signature	
Dr. Smith		Dr. Jones		N/A		N/A		N/A		N/A	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06497

6508

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>BALTIMORE</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE 1224</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>PULASKI TRAILER CAMP</b>	
3. NAME OF DECEASED (Type or print) <b>MILDRED</b> First Middle Last <b>PRENDER</b>		4. DATE OF DEATH Month <b>6</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6.19.20</b>
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES LADY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FREDERICK CISEL</b>		14. MOTHER'S MAIDEN NAME <b>CLARITA WALTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) <b>9</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TUBERCULOUS EMBRYEMA (LFT)</b> DUE TO <b>FAR ADVANCED PULM. TUBERCULOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>5 years</b> (c) <b>2 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>COR PULMONALE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-24</b> , 19 <b>58</b> , to <b>6-26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6-26</b> , 19 <b>59</b> , and that death occurred at <b>6:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Newcomer</b>		ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/30/59</b>		22b. DATE THEREOF <b>6/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of Mercy</b>		22d. LOCATION (City, town, or county) (State) <b>Dyersville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Trinity Funeral Home, Dyersville</b>		ADDRESS <b>1401 A.P. Benedict Road, Dyersville, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
1908  
CERTIFICATE OF DEATH

1

NAME OF DECEASED  
RESIDENCE  
AGE  
SEX  
DATE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
DISEASE  
MANNER OF DEATH  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF WITNESSES  
OFFICIAL USE

6399

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>				c. LENGTH OF STAY IN 1b <b>33 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>74 Kinship Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ERNEST VICTOR PRICE</b>				4. DATE OF DEATH Month Day Year <b>June 12th, 1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 16, 1887</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shearman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Price</b>				14. MOTHER'S MAIDEN NAME <b>Beatrice Scriven</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-07-4422</b>		17. INFORMANT <b>Ann M. Price</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis - Intestine</b> DUE TO <b>Cancer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer</b> DUE TO (c) <b>Cancer</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>23 Apr. 1959</b> to <b>12 June 1959</b> , that I last saw the deceased alive on <b>11 June 1959</b> , and that death occurred at <b>12 June 1959</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3 Kinship Road</b> DATE SIGNED <b>W. Herbert Morrison</b>							
ACTUAL SIGNATURE <b>W. Herbert Morrison</b> M.D. <b>3 Kinship Road</b>							
PHYSICIAN'S NAME (Type) <b>W. Herbert Morrison, M.D.</b> <b>Baltimore 22, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. B. Brock</b>				ADDRESS <b>Dundalk 22</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6509

## CERTIFICATE OF DEATH

06499

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>27 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>H.</b> Last <b>PUSSLER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 4, 1918</b>
9. AGE (In years lost birthday) yrs. <b>41</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Great Mills, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nicholas Pussler</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Dean</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>219 03 9831</b>	
17. INFORMANT <b>Clinical Rec. VA Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DISSEMINATED MALIGNANT MELANOMA: BRAIN, HEART, LIVER, SPLEEN, KIDNEYS, LYMPH NODES, ADRENALS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 23</b> , 19 <b>59</b> , to <b>June 19</b> , 19 <b>59</b> , and that death occurred at <b>10:00 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA Hospital, Ft. Howard, Md. 6/20/59</b>			
ACTUAL SIGNATURE <b>W. J. Pijanowski</b>		M.D. <b>VA Hospital, Ft. Howard, Md. 6/20/59</b>	
PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>		<b>VA Hospital, Ft. Howard, Md. 6/20/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-23-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Ritchie Highway, Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight</b>		ADDRESS <b>6009 Harford Rd.</b>	
24a. REC'D BY REGISTRAR <b>JUN 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

WM. COOK-BLIGHT, INC. 6009 HARFORD RD. BALTO MD

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
Baltimore, Md.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1900	
Residence		Occupation		Cause of Death		Place of Death	
123 Main St, Baltimore, Md.		Teacher		Heart Disease		Home	
Date of Death		Time of Death		Physician		Hospital	
Jan 15, 1945		10:30 AM		Dr. J. Smith		St. Mary's Hospital	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]	

6510 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8109 Wilson Ave.</i>		e. STREET ADDRESS <i>1 8109 Wilson Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Katie</i> First Middle <i>A.</i> Last <i>Raver</i>		4. DATE OF DEATH <i>June</i> Month <i>7</i> Day <i>19</i> Year <i>59</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 25, 1879</i>
9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Marysville, Penna</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George W. Eby</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane File</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <i>Mr. Donald Raver, 8109 Wilson Avenue.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>May 27, 1959</i> <i>1 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June</i> , 19 <i>58</i> , to <i>June 1</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>June 1</i> , 19 <i>59</i> , and that death occurred at <i>10:19 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. J. Alessi</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>6217 Hartford Rd Baltimore - 14, Md</i>	
PHYSICIAN'S NAME (Type) <i>E. J. Alessi M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/4/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Hartford Road.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 4 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6511

## CERTIFICATE OF DEATH

06501

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8601 Richmond Circle</u>				d. STREET ADDRESS <u>1 8601 Richmond Circle</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>M.</u> Last <u>Reeves</u>				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-2-1883</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank Reeves</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Blair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Marjorie Flater</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>733X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypostatic pneumonia</u> DUE TO (c) <u>Osteoporosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>One day</u> <u>7 days</u> <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/31</u> , 19 <u>58</u> , to <u>6/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/26</u> , 19 <u>59</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Conrad L. Richter</u> M.D.				ADDRESS (Street, city or town, state) <u>3128 Harford Rd</u> DATE SIGNED <u>7/1/59</u>			
PHYSICIAN'S NAME (Type) <u>Conrad L. Richter</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 6 1959</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. &amp; K. H.</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No.

Arthur E. Thomas

CERTIFICATE OF DEATH

Age

Sex

(Date of Birth) (Month) (Day) (Year)

3101 Maryland Avenue

(Occupation)

Charles B. Miller

Y. N. (Cause of Death)

U.S.A.

Residence

Home

Residence

State of Maryland

James B. Miller

James B. Miller, 3101 Maryland Ave., Baltimore

No. 1 - 1915

James B. Miller, 3101 Maryland Ave., Baltimore

James B. Miller, 3101 Maryland Ave., Baltimore

James B. Miller, 3101 Maryland Ave., Baltimore

James B. Miller, 3101 Maryland Ave., Baltimore

James B. Miller, 3101 Maryland Ave., Baltimore

James B. Miller, 3101 Maryland Ave., Baltimore

James B. Miller, 3101 Maryland Ave., Baltimore

Dr. Olive Conner

Baltimore, Md.

528 Liberty Road

Baltimore, Md.

6513

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>City Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		c. LENGTH OF STAY IN 1b <u>1 year.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>Paul</u> Last <u>Roberts</u>		4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/57</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>14</u> Hours <u>19</u> Min. <u>59</u>	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Leonard Roberts</u>	
14. MOTHER'S MAIDEN NAME <u>Geraldine B. Roberts</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>-----</u>		INFORMANT <u>Rosewood Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia of right lung</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple malformations</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:45a</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Dr. W. Rieckert, Pathologist</u>		ADDRESS (Street, city or town, state) <u>4307 Madison</u> DATE SIGNED <u>6/15/59</u>	
PHYSICIAN'S NAME (Type) <u>P. W. Rieckert</u>		<u>Baltimore 14, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6-16-59</u>	<u>Oak Hill</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc. 2100 Eutan Plac.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>C. E. Jones</u>			

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

100013

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK

IN SENATE  
JANUARY 1, 1913

REPORT  
OF THE

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
JANUARY 1, 1913  
REPORT  
OF THE  
ATTORNEY GENERAL  
TO THE SENATE  
AND ASSEMBLY  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JUNE 1, 1912  
AND BY THE ASSEMBLY  
JULY 1, 1912  
RELATIVE TO THE  
ADMINISTRATION OF THE  
OFFICE OF THE ATTORNEY GENERAL  
DURING THE YEAR  
ENDING DECEMBER 31, 1912  
ALBANY: J.B. LIPPINCOTT COMPANY  
1913

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6514 CERTIFICATE OF DEATH

06504

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN TB <u>11 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7834 Bagley Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILHELMINA</u> First <u>E</u> Middle <u>ROBINSON</u> Last		4. DATE OF DEATH <u>JUNE 10 1959</u> Month <u>JUNE</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUN 10, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM AUER</u>		14. MOTHER'S MAIDEN NAME <u>BERHARDINA KUNDELMEIER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-24-8719</u>	
17. INFORMANT <u>WILLIAM L. H. ROBINSON</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Cardio Vase Dis.</u> DUE TO (c) <u>Arabeles</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Jejunum dermal fistula</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 10 1959</u> to <u>June 10 1959</u> that I last saw the deceased alive on <u>June 10 1959</u> and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 Hartford Rd, Balto 14, Md.</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T KASIK JR.</u>		DATE SIGNED <u>6/11/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 13, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Lun. Church</u>	22d. LOCATION (City, town, or county) (State) <u>PARKVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F EVANS &amp; SON</u> ADDRESS <u>8802 HARTFORD RD</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 15 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# 1 M 014 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 M 014 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6515 CERTIFICATE OF DEATH

Reg. Dist. No.

06505

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. STREET ADDRESS <u>6501 Dalcy Road - S. E.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u>		4. DATE OF DEATH <u>June 7 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary abscesses</u> <u>521x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardiovascular disease - Carcinoma of rectum</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 15</u> 19 <u>59</u> , to <u>June 7</u> 19 <u>59</u> , that I last saw the deceased alive on <u>June 7</u> 19 <u>59</u> , and that death occurred at <u>1:35p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Isadore Tuerk</u>		DATE SIGNED <u>6-8-59</u>	
PHYSICIAN'S NAME (Type) <u>Isadore Tuerk, M.D.</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		4739 <u>Baltimore Ave.</u> <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUN 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



6516 CERTIFICATE OF DEATH

06506

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Catherine Rogusky</i>		2. DATE OF DEATH <i>6/29/59</i>	
3. PLACE OF DEATH A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Balt</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>7257 Lough St</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
D. STREET ADDRESS (If rural, give location) <i>7257 Lough St</i>			
6. SEX <i>Female</i>	7. COLOR OR RACE <i>White</i>	8. DATE OF BIRTH <i>May 15, 1899</i>	9. AGE (In years last birthday) <i>60</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife at home</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Vincent Rogusky</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <i>Mr. Joseph A. Rogusky</i>	
		ADDRESS	

18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH <i>Coronary occlusion</i> <i>Chronic heart failure</i>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

22. I certify that (I) (this hospital) attended the deceased from *June 29, 1959* to *June 29, 1959*, that (I) (we) last saw the deceased alive on *June 29, 1959*, and that in (my) (our) opinion death occurred at *3 a.m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Stanley Ammerlaan</i>	23B. ADDRESS <i>1802 W. 130th</i>	23C. DATE SIGNED <i>6/29/59</i>
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>7/2/59</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Madowridge Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Washington Rd Md.</i>
DATE RECEIVED BY REGISTRAR <i>JUN 30 '59</i>	REGISTRAR'S SIGNATURE <i>Arthur S. Klaus</i>	25. FUNERAL DIRECTOR <i>Robert A. Cowan</i>	
		ADDRESS <i>11th</i>	

THIS IS A PERMANENT RECORD

PLEASE TYPE, OR PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN

Every item of informat carefully supplied. Physicians: please write the causes of death clearly and legibly.

THIS CERTIFICATE MUST BE THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DI





## 150

8092-20-523

[illegible]

6518

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED  
(Type or Print)

GERTRUDE E. ROSENTHAL

2. DATE OF DEATH

June 9, 1959

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore County*  
B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE *Baltimore 72 -*  
*Armacost Nursing Home*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Md.*

B. COUNTY

*BALTO. CO.*C. CITY OR TOWN (If outside city limits, write RURAL and give township)  
*Baltimore*

D. STREET ADDRESS (If rural, give location)

*1641 Northgate Road - 18*

5. SEX

*female*

6. COLOR OR RACE

*white*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*widowed*

8. DATE OF BIRTH

*6/5/1862*

9. AGE (In years last birthday)

*77*

If Under 1 Year

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Secretary*

10B. KIND OF BUSINESS OR INDUSTRY

*U.S. Gov't.*

11. BIRTHPLACE (State or foreign country)

*Baltimore, Md.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Unknown*

14. MOTHER'S MAIDEN NAME

*Unknown*15. Was Deceased Ever in U.S. Armed Forces?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Charles S. Leimbach, cousin, above*18. *420.1*

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## CAUSE OF DEATH

*Acute Coronary Thrombosis*

DUE TO

*Hypertensive Cardiovascular*

DUE TO

*Heart disease*

(C)

INTERVAL BETWEEN ONSET AND DEATH

*36 hr.**year*

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒22. I certify that (I) (this hospital) attended the deceased from *June 9, 1959* to *June 9, 1959*, that (I) (we) last saw the deceased alive on *June 5, 1959*, and that in (my) (our) opinion death occurred at *6 A.M.*, from the causes and on the date stated above.

22A. SIGNATURE

*Robert R. Leong*MED. DIRECTOR ☐

STAFF PHYS.

23B. ADDRESS

*3025 Belair Rd*

23C. DATE SIGNED

*6-10-59*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*6/12/59*

24C. NAME OF CEMETERY OR CREMATORY

*Loudon Park Cemetery*

24D. LOCATION (City, town, or county)

*Baltimore, Md.*

DATE RECEIVED BY REGISTRAR

*JUN 16 1959*

REGISTRAR'S SIGNATURE

*Handwritten signature*

25. FUNERAL DIRECTOR

ADDRESS

*Schimunek Funeral Home, Inc.  
2601-3-5 E. Madison St.*THIS IS A PERMANENT RECORD  
PLEASE TYPE, OR IF PERMANENT BLACK OR BLUE-INK, DO NOT USE A BALL POINT PEN  
Every item of information carefully supplied. Physicians: please write the causes of death clearly and legibly.

THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER I

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

NAME OF DECEASED: \_\_\_\_\_  
AGE: \_\_\_\_\_ SEX: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
PLACE OF BIRTH: \_\_\_\_\_  
MARRIAGE: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_  
EDUCATION: \_\_\_\_\_  
RELIGION: \_\_\_\_\_  
MILITARY SERVICE: \_\_\_\_\_  
DATE OF DEATH: \_\_\_\_\_  
PLACE OF DEATH: \_\_\_\_\_  
CAUSE OF DEATH: \_\_\_\_\_  
MANNER OF DEATH: \_\_\_\_\_  
SIGNATURE OF DECEASED: \_\_\_\_\_  
SIGNATURE OF WITNESS: \_\_\_\_\_  
SIGNATURE OF PHYSICIAN: \_\_\_\_\_  
SIGNATURE OF CLERK: \_\_\_\_\_  
DATE OF REGISTRATION: \_\_\_\_\_  
PLACE OF REGISTRATION: \_\_\_\_\_

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06509

6519

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>128 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>E.</b> Last <b>RUFF</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/2/12</b>
9. AGE (In years last birthday) yrs. <b>47</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Road Equip. Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. County</b>	
11. BIRTHPLACE (State or foreign country) <b>Catonsville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob V. Ruff</b>		14. MOTHER'S MAIDEN NAME <b>Mary MN: <del>Case</del> HAKER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SQUAMOUS CARCINOMA OF LARYNX WITH METASTASIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 19, 1959</b> , to <b>June 27, 1959</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>C. B. Cope, M.D.</b>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>C. B. COPE, M.D.</b>		<b>VAH, FORT HOWARD, MARYLAND 6/27/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-1-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>4300 Old Frederick Rd. Balto, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George A. Farley Funeral Home, Baltimore, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUL 2 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)  
15M 10/57

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6520 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06510**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>			c. LENGTH OF STAY IN 1b  			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 ESSEX</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8104 EASTERN AVENUE</b>				d. STREET ADDRESS <b>1 8104 EASTERN AVENUE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Charles</b> Middle <b>Henry</b> Last <b>Sachs</b>				<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>8</b> Year <b>19 59</b>									
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>DEC. 18, 1885</b>		<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>OIL CO.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>BALTIMORE MARYLAND</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>HENRY SACHS</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>CARRIE SEABODE</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>213 10 8987</b>		<b>17. INFORMANT</b> <b>EMMA WEGMAN</b> Address <b>SISTER</b> <b>MRS KATHERINE SACHS</b> <b>SISTER IN LAW</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Hypertensive Cardiovascular disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b>  <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
<b>ACTUAL SIGNATURE</b> <i>Jack E. Pollins</i>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <b>6-8-59</b>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>				<b>22b. DATE THEREOF</b> <b>6/9/59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>WOODLAWN CEMETERY</b>				<b>22d. LOCATION</b> (City, town, or county) (State) <b>WOODLAWN MARYLAND.</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HENRY SANDER &amp; SONS INC.</b> <b>BALTIMORE 13, MARYLAND.</b>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUN 10 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Frank</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

POST-MORTEM EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]		AGE [Handwritten: 45]		DATE OF DEATH [Handwritten: 10/15/1918]	
PLACE OF DEATH [Handwritten: Home]		OCCASION OF DEATH [Handwritten: Natural]		CAUSE OF DEATH [Handwritten: Heart Disease]		MANNER OF DEATH [Handwritten: Natural]	
TIME OF DEATH [Handwritten: 10:00 AM]		PLACE OF BURIAL [Handwritten: St. Mary's Cemetery]		NAME OF BURIAL PLACE [Handwritten: St. Mary's Cemetery]		NAME OF MINISTER [Handwritten: Rev. J. M. Smith]	
NAME OF PHYSICIAN [Handwritten: Dr. J. M. Smith]		NAME OF SURGEON [Handwritten: Dr. J. M. Smith]		NAME OF PATHOLOGIST [Handwritten: Dr. J. M. Smith]		NAME OF ANATOMIST [Handwritten: Dr. J. M. Smith]	
NAME OF ASSISTANT [Handwritten: Dr. J. M. Smith]		NAME OF NURSE [Handwritten: Dr. J. M. Smith]		NAME OF ATTENDING CLERGYMAN [Handwritten: Rev. J. M. Smith]		NAME OF MINISTER [Handwritten: Rev. J. M. Smith]	
NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]		AGE [Handwritten: 45]		DATE OF DEATH [Handwritten: 10/15/1918]	
PLACE OF DEATH [Handwritten: Home]		OCCASION OF DEATH [Handwritten: Natural]		CAUSE OF DEATH [Handwritten: Heart Disease]		MANNER OF DEATH [Handwritten: Natural]	
TIME OF DEATH [Handwritten: 10:00 AM]		PLACE OF BURIAL [Handwritten: St. Mary's Cemetery]		NAME OF BURIAL PLACE [Handwritten: St. Mary's Cemetery]		NAME OF MINISTER [Handwritten: Rev. J. M. Smith]	
NAME OF PHYSICIAN [Handwritten: Dr. J. M. Smith]		NAME OF SURGEON [Handwritten: Dr. J. M. Smith]		NAME OF PATHOLOGIST [Handwritten: Dr. J. M. Smith]		NAME OF ANATOMIST [Handwritten: Dr. J. M. Smith]	
NAME OF ASSISTANT [Handwritten: Dr. J. M. Smith]		NAME OF NURSE [Handwritten: Dr. J. M. Smith]		NAME OF ATTENDING CLERGYMAN [Handwritten: Rev. J. M. Smith]		NAME OF MINISTER [Handwritten: Rev. J. M. Smith]	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6521

## CERTIFICATE OF DEATH

06511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 17301-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIDGEWAYMANOR NURSEING HOME</u>		d. STREET ADDRESS <u>1221 WALTERS AVE</u>	
3. NAME OF DECEASED (Type or print) <u>Edward R. SALISBURY</u>		4. DATE OF DEATH <u>JUNE 30 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Oct 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER RET</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rock Hall Md</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward SALISBURY</u>		14. MOTHER'S MAIDEN NAME <u>ANNA WATSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-09-1533</u>	
17. INFORMANT <u>JAMES H. SALISBURY</u>		Address <u>1221 WALTERS AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET OF DEATH <u>6 hrs.</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 1956</u> , to <u>June 30 1959</u> , that I last saw the deceased alive on <u>June 29 1959</u> , and that death occurred at <u>1:35 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1 Mallow Hill Ave.</u> DATE SIGNED <u>6/30/59</u>			
ACTUAL SIGNATURE <u>Leo J. Gaver</u>		M.D. <u>Baltimore 29, Maryland.</u>	
PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3 July 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WESLEY CHAPEL CEM</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter P. Walters</u>		ADDRESS <u>Pratt, Strickland</u>	
24a. REC'D BY REGISTRAR <u>Jul 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
M. J. JONES		45		M		W		JAN 15 1920		BALTIMORE, MD.	
MANNER OF DEATH		CAUSE OF DEATH		DISEASE		COMPLICATIONS		TREATMENT		POST-MORTEM	
NATURAL		HEART DISEASE		CORONARY ARTERY DISEASE		HYPERTENSION		NONE		NONE	
DATE OF BURIAL		PLACE OF BURIAL		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF CHURCH	
JAN 18 1920		BALTIMORE, MD.		JONES & SONS		J. J. JONES		J. J. JONES		ST. JAMES CHURCH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYMAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CHURCH	
DATE OF CERTIFICATE		PLACE OF CERTIFICATE		NAME OF REGISTRAR		NAME OF CLERK		NAME OF CHIEF CLERK		NAME OF ASSISTANT CLERK	
JAN 18 1920		BALTIMORE, MD.		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6522

## CERTIFICATE OF DEATH

06512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 TOWSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AIGBURTH MANOR</b>		d. STREET ADDRESS <b>AIGBURTH MANOR</b>	
3. NAME OF DECEASED (Type or print) <b>GEORGE FRANKLIN SARGENT</b>		4. DATE OF DEATH <b>JUNE 7 1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 12, 1878</b>
9. AGE (In years last birthday) <b>80</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN</b>	
11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOSEPH B. SARGENT</b>		14. MOTHER'S MAIDEN NAME <b>GERTUDE COOK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES. I.W.W.I.</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>JAMES G. MACABE</b>		Address <b>4818 KESWICK RD. 10.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Sclerosis</b> <b>420.1</b> DUE TO <b>hypertensive C-V. Renal</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Disease</b> (c) <b>Disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis &amp; Semblity</b>			19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 1st 1958</b> to <b>June 7th 1959</b> , that I last saw the deceased alive on <b>June 7th 1959</b> , and that death occurred at <b>5:00</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M Paul Byrd</b> M.D.		ADDRESS (Street, city or town, state) <b>3033 W. North Ave</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>M Paul Byrd MD Balto 10 med</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-10-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L</b>	22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. JENKINS &amp; Sons Co.</b> ADDRESS <b>4905 York Rd. Balto. 12</b>		24a. REC'D BY REGISTRAR <b>JUN 10 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6523

## CERTIFICATE OF DEATH

06513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>57 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>	
f. STREET ADDRESS <b>2233 Essex Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LAWRENCE J. SAS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 7, 1892</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vulcanizer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tire Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Sas</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Gzeck</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>		16. SOCIAL SECURITY NO. <b>220-24-5149</b>	
17. INFORMANT <b>Clinical Rec. VA Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA RIGHT LUNG</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>163X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY EMPHYSEMA, COR. PULMONALE.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Closed intercostal catheter drainage 5/7/59</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1</b> , 19 <b>59</b> , to <b>June 27</b> , 19 <b>59</b> , and that death occurred on <b>5:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA Hospital, Ft. Howard, Md.</b> DATE SIGNED <b>6/27/59</b>			
ACTUAL SIGNATURE <b>C. B. COPE, M.D.</b>		PHYSICIAN'S NAME (Type) <b>C. B. COPE, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/1/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>6515 Boston St., Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles D. Sedowski</b>		24a. REC'D BY REGISTRAR <b>JUN 30 '59</b>	
ADDRESS <b>1937 Gough St., Balto., Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text, possibly "John Doe"]</p>		<p>2. SEX                  [Faint text, possibly "Male"]</p>		<p>3. AGE                  [Faint text, possibly "45"]</p>	
<p>4. DATE OF DEATH                  [Faint text, possibly "Jan 15, 1920"]</p>		<p>5. TIME OF DEATH                  [Faint text, possibly "10:30 AM"]</p>		<p>6. PLACE OF DEATH                  [Faint text, possibly "Home"]</p>	
<p>7. CAUSE OF DEATH                  [Faint text, possibly "Heart Disease"]</p>		<p>8. MANNER OF DEATH                  [Faint text, possibly "Natural"]</p>		<p>9. SIGNATURE OF PHYSICIAN                  [Faint text, possibly "Dr. J. Smith"]</p>	
<p>10. SIGNATURE OF REGISTRAR                  [Faint text, possibly "A. B. Jones"]</p>		<p>11. SIGNATURE OF WITNESS                  [Faint text, possibly "C. D. Brown"]</p>		<p>12. SIGNATURE OF DECEASED                  [Faint text, possibly "John Doe"]</p>	

6524

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>36 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>408 Edsdale Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>NORMAN</b> Middle <b>W.</b> Last <b>SAUER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/6/96</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>3</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accident Investigator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State of Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Werner Sauer</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Daubert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-33-6927</b>	
17. INFORMANT <b>Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT WITH LEFT HEMIPARESIS</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>VA</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>I</b> attended the deceased from <b>May 22</b> , 19 <b>59</b> , to <b>June 27</b> , 19 <b>59</b> , and that death occurred at <b>11:05 P.M.</b> , from the causes and on the date stated above <b>ADDRESS (Street, city or town, state)</b> <b>DATE SIGNED</b>			
ACTUAL SIGNATURE <b>Moses Lichtig</b>		M.D. <b>VAH, Fort Howard, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>MOSES LICHTIG, M.D.</b>		<b>VAH, Fort Howard, Maryland</b> <b>6/28/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 1, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Teufel</b> <b>John F. Teufel Funeral Home, 5311 Edmondson Ave., Baltimore, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>			

VS A15 (4)  
15M 10/57

VS A15 (4)  
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6525

## CERTIFICATE OF DEATH

Reg. Dist. No.

06515

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN TB <b>1yr 7mth 3dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>914 S. Carey Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>(SWETTA SOVERN) (First) (CVETA SAVIN) (Middle) Sweater</b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>March 22, 1875</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TRANSIT Co - Baltimore</b>	
11. BIRTHPLACE (State or foreign country) <b>Yugoslavia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Yugoslavia</b>	
13. FATHER'S NAME <b>Michael Savin</b>		14. MOTHER'S MAIDEN NAME <b>Katie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown No</b>		16. SOCIAL SECURITY NO. <b>713-05-9568</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 28</b> , 19 <b>58</b> , to <b>June 22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 22</b> , 19 <b>59</b> , and that death occurred at <b>3:45 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b> <b>6-22-59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Burial</b>		<b>20 JUNE 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>GLEN HAVEN CEM</b>		<b>H.A. Co md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nottingham B. M. Walters</b>		ADDRESS <b>Stricker St</b>	
24a. REC'D BY REGISTRAR <b>JUN 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6525

## CERTIFICATE OF DEATH

06516

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. LENGTH OF STAY IN 1b <i>X Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3016 Putty Hill Ave.</i>		e. STREET ADDRESS <i>3016 Putty Hill Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Margaret</i> Middle <i>Pauline</i> Last <i>Scheel</i>		4. DATE OF DEATH Month <i>June</i> Day <i>7</i> Year <i>19 59</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-12-1897</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas V. O'Connell</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Gormley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Henry C. Scheel</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Occlusion.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Interarteriosclerotic</i> DUE TO <i>Cardiovascular disease</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>5+ yr</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>3:39</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank T. Kasik</i>		ADDRESS (Street, city or town, state) <i>9005 Harford Rd Baltimore Md.</i>	
PHYSICIAN'S NAME (Type) <i>FRANK T KASIK</i>		DATE SIGNED <i>6/5/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-8-1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 8 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE OF ILLINOIS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1900

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1855		CHICAGO, ILL.	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 15 1880		CHICAGO, ILL.		JAMES H. HARRIS		JAN 15 1900		CHICAGO, ILL.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SPECIAL INSTRUCTIONS	
HEART DISEASE		NATURAL		FARMER		HIGH SCHOOL		METHODIST			
SIGNATURE OF PHYSICIAN		DATE		SIGNATURE OF REGISTRAR		DATE		SIGNATURE OF WITNESS		DATE	
JAMES H. HARRIS		JAN 15 1900		JAMES H. HARRIS		JAN 15 1900		JAMES H. HARRIS		JAN 15 1900	

1

6527 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>3V01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>MAY 1-1959</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN THE PINES</u>		d. STREET ADDRESS <u>370 MARY DELL RD</u>	
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>M. SchoFIELD</u> Last <u></u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 JULY 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO Md</u>	11. BIRTHPLACE (State or foreign country) <u>BALTO Md</u>
12. CITIZEN OF WHAT COUNTRY? <u></u>		13. FATHER'S NAME <u>GEORGE D. MARK</u>	
14. MOTHER'S MAIDEN NAME <u>ELIZABETH SCHMIDT</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MORRIS M. WITHROW</u> Address <u>370 MARY DELL RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardio-vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 31, 1958</u> , to <u>June 28, 1959</u> , that I last saw the deceased alive on <u>June 28, 1959</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A Knipp</u> M.D.		ADDRESS (Street, city or town, state) <u>4116 Edmondson Ave Baltimore, Md</u> DATE SIGNED <u>June 29 1959</u>	
PHYSICIAN'S NAME (Type) <u>George A Knipp MD</u>		<u>BALTO, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>30 JUNE 1959</u>	<u>HOUDON PARK</u>	<u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter M. Waters</u>		ADDRESS <u>1414 Sticker</u>	
24a. REC'D BY REGISTRAR <u>JUN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. DEATH CERTIFICATE

Register No.

Place of Death

Residence

Place of Birth

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

DEPARTMENT OF HEALTH



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD., AND A COPY OF IT IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

## 6528 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owens Mills</u>		c. LENGTH OF STAY IN 1b <u>301-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Foxleigh Home</u>		d. STREET ADDRESS <u>Madison Ave + Cloverdale Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>REBECCA</u> Middle <u>Schwaber</u> Last <u>Schwaber</u>		4. DATE OF DEATH Month <u>6</u> - Day <u>26</u> - Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>94</u> yrs.
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months <u>94</u> Days <u>94</u> Hours <u>94</u> Min. <u>94</u>	11. IF UNDER 24 HRS. Months <u>94</u> Days <u>94</u> Hours <u>94</u> Min. <u>94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUSTRIA</u>	
11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>15946</u>		14. MOTHER'S MAIDEN NAME <u>58944</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>MILTON SCHWABER - 3239 POWATTAN AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Uremia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1925</u> to <u>6-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-25</u> , 19 <u>59</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. J. Jussman</u>		ADDRESS (Street, city or town, state) <u>3101 N. Charles St</u> DATE SIGNED <u>6-26-59</u>	
PHYSICIAN'S NAME (Type) <u>A. A. Sussman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-28-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROSEDALE</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eaton Place</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thompson</u>

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)  
15M 9/58



*[Faint, mostly illegible text from a form, likely containing vehicle details and owner information.]*

REGISTERED  
IN THE STATE OF

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6529

## CERTIFICATE OF DEATH

06519

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>lyrllmth23dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. STREET ADDRESS <u>McDonough Road</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <u>Winfield</u></span> <span>Middle</span> <span>Last <u>Scott</u></span> </div>				<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>Month <u>June</u></span> <span>Day <u>9</u></span> <span>Year <u>1959</u></span> </div>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 19, 1872</u>	
<b>9. AGE</b> (In years last birthday) yrs. <u>87</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>construction worker - Carpenter -- Lumber</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Stephen Darius Scott</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Elizabeth Kendall</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>212-26-9080</u>		<b>17. INFORMANT</b> <u>Records: SPRING GROVE STATE HOSPITAL</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex;"> <div style="flex: 1;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <u>Emaciation + dehydration</u>            191.3 DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma, epididymal of the jaw</u>            DUE TO (c)         </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 5px;">           INTERVAL BETWEEN ONSET AND DEATH         </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>April 8, 1958</u> , to <u>June 8, 1959</u> , that I last saw the deceased alive on <u>June 9, 1959</u> , and that death occurred at <u>1:10 A.M.</u> from the causes and on the date stated above. <div style="display: flex; justify-content: space-between;"> <div> <b>ACTUAL SIGNATURE</b>  <u>Isadore Tuerk, M.D.</u> </div> <div> <b>ADDRESS</b> (Street, city or town, state)  <u>SPRING GROVE STATE HOSPITAL</u> </div> <div> <b>DATE SIGNED</b>  <u>6-9-59</u> </div> </div>							
<b>PHYSICIAN'S NAME (Type)</b> <u>Catonsville 28, Maryland</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>6/11/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cem.</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Baltimore, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. Pickner &amp; Sons - Baltimore</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>JUN 9 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Knepp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

**6530**

**CERTIFICATE OF DEATH**

**06520**

**Reg. Dist. No.**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN lb <b>45 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1311 St Albans Rd</b>		e. STREET ADDRESS <b>1311 St Albans Rd</b>	
3. NAME OF DECEASED (Type or print) <b>Mollie</b> First <b>Seidman</b> Middle Last		4. DATE OF DEATH <b>June 13</b> Month Day Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 5, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Poland</b>	
13. FATHER'S NAME <b>BENJAMIN Seidman</b>		14. MOTHER'S MAIDEN NAME <b>Leah Baginsky</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Abraham Seidman - 1311 St Albans Rd</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> <b>8 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct</b> , 1946, to <b>June</b> , 1959, that I last saw the deceased alive on <b>June 13</b> , 1959, and that death occurred at <b>6:40</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Isadore Kaplan</b> M.D.		ADDRESS (Street, city or town, state) <b>3314 Marnat Rd Baltimore Md</b> DATE SIGNED <b>6/13/59</b>	
PHYSICIAN'S NAME (Type) <b>ISADORE KAPLAN M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>6-14-59</b>	<b>Herring Run</b>	<b>Balte MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis</b> ADDRESS <b>2100 Euston Place</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 6531 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>700 N. Luzerne Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Served as First <b>IRWIN</b> J. Middle <b>SEYFFERTH</b> ) (Type or print) <b>IRVIN</b> J. <b>SEYFFERTH</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 7, 1903</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City Government</b>	9. AGE (In years last birthday) yrs. <b>55</b> IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Seyffferth</b>		14. MOTHER'S MAIDEN NAME <b>Ada Burke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>		16. SOCIAL SECURITY NO. <b>218-03-8765</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS OF UNKNOWN PRIMARY SITE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation - Subtotal gastric resection for bleeding duodenal ulcer 5/23/57</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 4, 1959</b> , to <b>June 16, 1959</b> , and that death occurred at <b>4:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, MARYLAND 6/17/59</b>			
ACTUAL SIGNATURE <b>W. W. Schier</b> M.D. <b>W. W. SCHIER, M.D., Director, Professional Services</b>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/19/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 18 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Orlind S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IT IS IN THE  
HAG COURT

PAID  
MAY 10 1900

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Date of Death		Place of Death		Cause of Death		Disease	
June 10, 1900		Home		Heart Disease		Myocardial Infarction	
Time of Death		Occupation		Signature of Physician		Signature of Registrar	
10:00 AM		Carpenter		[Signature]		[Signature]	
Manner of Death		Burial Place		Name of Burial Place		Name of Undertaker	
Natural		Catholic Cemetery		Catholic Cemetery		John Doe	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]	

6532

## CERTIFICATE OF DEATH

06522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GARRISON</b>				c. LENGTH OF STAY IN 1b <b>two Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FOXLEIGH NURSING HOME</b>				d. STREET ADDRESS <b>1527 EAST NORTH AVENUE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>E</b> Last <b>SHAEFER</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 16, 1894</b>	
9. AGE (In years lost birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR MENS CLOTHING</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MANUFACTURER</b>			
11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>BERNARD SCHAEFER</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET ULRICH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214 05 3639</b>			
17. INFORMANT <b>MR. THOMAS MAY</b>				Address <b>820 EAST NORTH AVENUE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>OBSTRUCTIVE JAUNDICE</b> 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Abdominal Carcinomatos</b> (c) <b>Papillary cystadenocarcinoma of ovary</b> Interval between onset and death <b>1 month</b> <b>unknown</b> <b>unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>APRIL 11</b> , 19 <b>59</b> , to <b>JUNE 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>MAY 31</b> , 19 <b>59</b> , and that death occurred at <b>7:30 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1422 Park Ave</b> DATE SIGNED ACTUAL SIGNATURE <b>Richard D. Hahn</b> M.D. <b>BALTO MD</b> PHYSICIAN'S NAME (Type) <b>RICHARD D HAHN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/5/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GARDEN OF FAITHS</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC</b> <b>BALTIMORE MARYLAND.</b>				24a. REC'D BY REGISTRAR <b>JUN 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06523  
6533 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN 1b <b>2yr3mth12dys</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park, Maryland 1617-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1208 Elson Place</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>Lee</b> Last <b>Sherier</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>78</b> Days <b>17</b> Hours <b>19</b> Min. <b>59</b>	IF UNDER 24 HRS. Months <b>78</b> Days <b>17</b> Hours <b>19</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>John C. Sherier</b>		14. MOTHER'S MAIDEN NAME <b>Mary M. Burch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic cardiovascular disease</b> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>On 5-20-59 patient fell, striking rt. side against wash basin, sustaining fractures of 11th and 10th rib posteriorly.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>10:20 AM 5-20 1959</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	20f. (City or town) (County) (State) <b>Catonsville 28, Maryland</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>George M. Kieffer</i>		DATE SIGNED <b>6-17-59</b>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 20, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Walker's Chapel</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chas. Chase</i>		24a. REC'D BY REGISTRAR <b>JUN 22 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>

MEDICAL CERTIFICATION

2

2

STATE OF  
DEATH CERTIFICATE

1

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of medical examiner  
10. Signature of registrar

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12 11 02  
CR33 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of medical examiner: [illegible]  
10. Signature of registrar: [illegible]

# 6534 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06524

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hereford</b>		c. LENGTH OF STAY IN 1b <b>15 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hereford</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>Parkton RD</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Wallace Bruce Simons</b>				<b>4. DATE OF DEATH</b> <b>June 28 1959</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>Jan. 8, 1888</b>		<b>9. AGE</b> (In years last birthday) <b>71 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Gen. Farming</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Grason Co. Virginia</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>Gus Simons</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Queen Copler</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>218-36-3377</b>		<b>17. INFORMANT</b> <b>Mrs. W. B. Simons</b> <span style="float: right;">Address <b>Parkton, Md.</b></span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>A. M. France</i> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>A.M. France</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <b>6/28/59</b>			
<b>22a. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>7/1/1959</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. James</b>			
<b>22d. LOCATION (City, town, or county)</b> <b>Monkton</b>		<b>(State)</b> <b>Maryland</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Charles E. Furb</i>		<b>ADDRESS</b> <i>Farrettsville</i>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>JUL 2 '59</b>			
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
 DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: John Doe  
 SEX: Male  
 AGE: 45  
 RACE: White  
 OCCUPATION: Teacher  
 RESIDENCE: 123 Main St, New York, N.Y.  
 DATE OF DEATH: Jan 15, 1920  
 PLACE OF DEATH: Home  
 CAUSE OF DEATH: Heart Disease  
 MANNER OF DEATH: Natural  
 SIGNATURE OF EXAMINER: J. H. Smith  
 OFFICE OF EXAMINER: New York City

1

6535

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - RANDALLSTOWN</u>				c. LENGTH OF STAY IN 1b <u>40 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8704 LIBERTY RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>G.</u> Last <u>SLEAKER</u>				4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 5, 1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spinner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton Mills</u>		11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Va.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Smith Sabbath Griffith</u>				
14. MOTHER'S MAIDEN NAME <u>Sarah A. Zindorf</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <u>213-05-0457</u>			17. INFORMANT <u>DAUGHTER</u> Address <u>MRS AGNES SNYDER 8704 LIBERTY RD RANDALLSTOWN</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Renal Disease</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>20 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>a. p.</u> <u>19</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)		20h. (State)		
21. I certify that I attended the deceased from <u>JUNE 25, 1959</u> to <u>JUNE 27, 1959</u> , that I last saw the deceased alive on <u>JUNE 26, 1959</u> , and that death occurred at <u>6:08 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>8704 LIBERTY RD, BALTO, MD</u> DATE SIGNED <u>6/29/59</u>							
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D.							
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Randallstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>				ADDRESS <u>8728 Liberty Road</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 1 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06526

6536

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore, Long Green, Md.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Green</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long Green, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor Green Smith</u>		4. DATE OF DEATH Month Day Year <u>June 10, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Long Green, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dr. John S. Green, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Ella Baldwin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>J. Jackson Smith</u>	
17. INFORMANT <u>J. Jackson Smith</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Hypertensive Cardiovas. Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 yrs.</u> (c) <u>10 min.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/7</u> , 19 <u>56</u> , to <u>6/10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/9</u> , 19 <u>59</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u> M.D.		DATE SIGNED <u>Fork Md.</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>		<u>FORK MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 13, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Sweet Air, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co., Balto. Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 12 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

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6537

CERTIFICATE OF DEATH

06527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>md.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BACK RIVER</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BACK RIVER, Md.</b>			
c. LENGTH OF STAY IN 1b <b>45 yrs.</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>829 BACK RIVER NECK Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				f. STREET ADDRESS <b>829 BACK RIVER NECK Rd.</b>			
3. NAME OF DECEASED (Type or print) <b>Rev. Elisha Smith</b>				4. DATE OF DEATH <b>JUNE 26, 1959</b>			
5. SEX <b>M.</b>		6. COLOR OR RACE <b>C.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 25, 1898</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR: Months <b>60</b> Days <b>60</b> Hours <b>60</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Clergy</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>WESTMORELAND Co., Va.</b>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>NELSON Smith</b>				14. MOTHER'S MAIDEN NAME <b>MARY NELSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Elsie Smith</b>				Address <b>829 BACK RIVER NECK Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular accident</b> <b>422.1</b> DUE TO <b>Arteriosclerotic Cardiovascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 yrs</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 1, 1959</b> to <b>June 26, 1959</b> , that I last saw the deceased alive on <b>June 26, 1959</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm. Cunningham</b> M.D.				ADDRESS (Street, city or town, state) <b>Balto 6 Md.</b>			
DATE SIGNED <b>6/29/59</b>							
PHYSICIAN'S NAME (Type) <b>Milton E. Elickson</b>							
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>6-29-59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY CEM.</b>				22d. LOCATION (City, town, or county) (State) <b>A. A. COUNTY, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Milton E. Elickson</b>				ADDRESS <b>1129 N. CAROLINE</b>			
24a. REC'D BY REGISTRAR <b>JUN 30 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur A. Harris</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06528

## 6538 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>55</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Codd Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET HELEN</b> Middle <b>SMITH</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>? ? 1873</b>
9. AGE (In years last birthday) <b>86</b>		10. IF UNDER 1 YEAR Months <b>86</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Schoolteacher- retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John James Smith</b>		14. MOTHER'S MAIDEN NAME <b>Bridget Scally</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio Vascular Disease</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 1956, to <b>MAY 15<sup>th</sup></b> , 1959, that I last saw the deceased alive on <b>MAY 15<sup>th</sup></b> , 1959, and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1927 York Rd, TOWSON, MD</b> DATE SIGNED <b>6/12/59</b> ACTUAL SIGNATURE <b>M. X. Quinn</b> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 13, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Maria Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Towson, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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CENTRAL OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6539 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06529

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>visiting</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>703 Main Street</b>			d. STREET ADDRESS <b>4716 Edmondson Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Clarkson</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>June</b> Day <b>12</b> , 1959 Year <b>19</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1954</b>		9. AGE (In years last birthday) <b>5</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Richard M. Smith</b>			14. MOTHER'S MAIDEN NAME <b>Margaret C. Jennings</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Richard M. Smith, 4716 Edmondson Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of base of skull</b> 812x DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased was struck by automobile.</b>			
20c. TIME OF INJURY Month, Day, Year <b>8</b> Hour <b>XX</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>	
				20f. (City or town) (County) (State) <b>Reisterstown, Balto., Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>D. D. Caples</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>6-12-59</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	
				22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>			24a. REC'D BY REGISTRAR <b>JUN 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6540

## CERTIFICATE OF DEATH

06530

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>61 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>H.</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 18, 1892</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>	
11. BIRTHPLACE (State or foreign country) <b>Gloucester Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carey Smith</b>		14. MOTHER'S MAIDEN NAME <b>Nannie Harrison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>215-22-3461</b>	
17. INFORMANT <b>Clinical Rec. VA Hospital Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF PANCREAS</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>April 21</b> , 19 <b>59</b> , to <b>June 21</b> , 19 <b>59</b> , and that death occurred at <b>2:05 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA Hospital, Ft. Howard, Md. 6/21/59</b>			
ACTUAL SIGNATURE <b>Stephen Toms M.D.</b> M.D.		PHYSICIAN'S NAME (Type) <b>STEPHEN TOMS, M.D.</b> VA Hospital, Ft. Howard, Md. 6/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rising Valley Bapt. Church</b>		22d. LOCATION (City, town, or county) (State) <b>Gloucester Co., Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall P. Hayes</b> ADDRESS <b>638 N. GILMOR ST BALTO MD</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 22 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles A. Hayes</b>			

MARSHALL P. HAYES FUNERAL HOME 638 N. GILMOR ST BALTO MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7543 Belair Rd.</u>				d. STREET ADDRESS <u>7543 Belair Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Sena</u> Middle <u>M.</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> , Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1874</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>	
13. FATHER'S NAME <u>John B. Clayton</u>				14. MOTHER'S MAIDEN NAME <u>Sarah DeMoss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Robert Smith</u> Address <u>7543 Belair Rd. 6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Myocardial degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hip fracture - bed ridden</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>June</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June</u> , 19 <u>59</u> , and that death occurred at <u>4:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>9005 Harford Rd. Balto 14 Ind</u>			
PHYSICIAN'S NAME (Type) <u>FRANK T KASIK JR.</u>				DATE SIGNED <u>July 2 '59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fork Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Fork, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Larsen Funeral Home</u>				ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneal</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO. 14

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

RECEIVED  
MAY 10 1914  
BALTIMORE

FRANK T. KAPLAN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6542

## CERTIFICATE OF DEATH

06532

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3V01-4</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>111 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>912 Honaker Court, Baltimore 25</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>912 Honaker Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>M.</b> Last <b>SNOW</b>				4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 11, 1921</b>		9. AGE (In years last birthday) <b>38</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Roofer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Roofing Company</b>		11. BIRTHPLACE (State or foreign country) <b>Elkton, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leonard Snow</b>				14. MOTHER'S MAIDEN NAME <b>Etta Breeden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 126-18-4979</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL METASTASIS</b> DUE TO <b>CARCINOMATOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>DUE TO RETICULUM CELL SARCOMA</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>4 MONTHS</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 3</b> , 19 <b>59</b> , to <b>June 22</b> , 19 <b>59</b> , and that I last saw the deceased alive on <b>June 22</b> , 19 <b>59</b> , and that death occurred at <b>12:15</b> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Crawford</b>				ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>6/22/59</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>				<b>VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md</b>				24a. REC'D BY REGISTRAR <b>JUN 29 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kears</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06533

6543

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 mi Hill Frederick Road</b>				d. STREET ADDRESS <b>8 mi Hill Frederick Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lillian Elsie Snowden</b>				4. DATE OF DEATH Month Day Year <b>June 19 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 15, 1871</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Alexander Williams</b>				14. MOTHER'S MAIDEN NAME <b>Rosaella Henson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs Lillian Whiting</b>		Address <b>8 mi Hill Frederick Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Arterio-sclerosis 13 yrs Imo.</b> DUE TO (c) <b>26 days</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. Arthritis : Obesity</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April-24th 1946</b> , to <b>June-19th 1959</b> , that I last saw the deceased alive on <b>June-19th 1959</b> , and that death occurred at <b>7.00PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Winters Lane Catonsville-28, Maryland.</b> DATE SIGNED <b>June-19-59</b>							
ACTUAL SIGNATURE <b>C.F. Maloney M.D.</b>				M.D. <b>57 Winters Lane</b>			
PHYSICIAN'S NAME (Type) <b>C.F. Maloney, M.D.</b>				Catonsville-28, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-23-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. Frances A. Hamsley</b>				ADDRESS <b>W. Biddle St</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 25 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hensel</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED Catherineville		NAME OF DECEASED Catherineville	
PLACE OF DEATH 3 mi Hill Frederick Road		PLACE OF DEATH 3 mi Hill Frederick Road	
DATE OF DEATH Jan. 18, 1971		DATE OF DEATH Jan. 18, 1971	
TIME OF DEATH 11:00 AM		TIME OF DEATH 11:00 AM	
PLACE OF BIRTH Baltimore, Md.		PLACE OF BIRTH Baltimore, Md.	
AGE 89		AGE 89	
SEX Female		SEX Female	
RACE White		RACE White	
OCCUPATION None		OCCUPATION None	
CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF WITNESS [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF DECEASED [Signature]	

6544

14

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Caronsville</u>		c. LENGTH OF STAY IN 1b <u>7 1/4 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines</u>		d. STREET ADDRESS <u>4109 Alto Road</u>	
3. NAME OF DECEASED (Type or print) <u>Lois Mae Spamer</u>		4. DATE OF DEATH <u>June - 20 - 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 22/1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 YRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Carl G. C. Spamer</u>		14. MOTHER'S MAIDEN NAME <u>Abbie Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Wm F. Singler - 74d Unit - Ballo 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompenation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>103p.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-26-1958</u> to <u>6-20-1959</u> , that I last saw the deceased alive on <u>6-20-1959</u> , and that death occurred at <u>1045 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		M.D. <u>6209 Frederick Ave.</u> <u>6-22-59</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		<u>Baltimore - 25, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>June 23/59</u>	<u>Loeclerch Ph</u>	<u>Baltimore 29</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart M. Mowals</u>		ADDRESS <u>Ballo - 1 - Md</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19

REG. NO. 100

1. NAME OF DECEASED JAMES E. SMITH		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1918		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1945		9. PLACE OF MARRIAGE Baltimore, Md.		10. NAME OF SPOUSE Mary E. Smith	
11. CAUSE OF DEATH Heart Disease		12. ICD-9 CODE 410		13. PLACE OF DEATH Home		14. DATE OF DEATH 1963		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF PHYSICIAN J. E. Smith		17. SIGNATURE OF REGISTRAR J. E. Smith		18. SIGNATURE OF WITNESS J. E. Smith		19. SIGNATURE OF WITNESS J. E. Smith		20. SIGNATURE OF WITNESS J. E. Smith	

1. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

2. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

3. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

4. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

5. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

6. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

7. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

8. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

9. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

10. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6545 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06535

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> <span style="float: right;">b. COUNTY</span>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>			c. LENGTH OF STAY IN 1b <u>0</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hammonds Ferry Rd. nr Patapsco River</u>				d. STREET ADDRESS <u>714 W. Lombard St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>John Anthony Joseph Sparrow</u>				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>30</u> Year <u>1959</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Wh</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>April 20, 1924</u>		<b>9. AGE</b> (In years last birthday) <u>35</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Anthony J. Sparrow</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Augusta Wilkinson</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)		<b>17. INFORMANT</b> Address <u>Anthony J. Sparrow 714 W. Lombard St.</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>929.8</u> DUE TO <u>Drowning while swimming in pond or abandoned lake</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Accident</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Drowning while swimming</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>10 p. m. June 30 1959</u>			<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Lake or pond</u>		<b>20f. (City or town)</b> (County) (State) <u>Lansdowne Balto. Md</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input type="checkbox"/> , <b>Accident</b> <input checked="" type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .								
<b>ACTUAL SIGNATURE</b> <u>Geo. S. M. Kieffer</u>					<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>June 30. 59</u>	
<b>EXAMINER'S NAME (Type)</b> <u>Geo. S. M. Kieffer M.D.</u>					<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>			<b>22b. DATE THEREOF</b> <u>7-2-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Peters Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Wm. Cook, Inc. 1217 St. Paul St. Balto.</u>					<b>24a. REC'D BY REGISTRAR</b> <u>JUL 6 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6546

## CERTIFICATE OF DEATH

06536

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. LENGTH OF STAY IN 1b <b>55 Wiltondale Towson 4,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>College Manor</b>		d. STREET ADDRESS <b>509 Wilton Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>BESSIE</b> First Middle Last		4. DATE OF DEATH <b>June 10, 19 59</b> Month Day Year	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1862</b>
9. AGE (In years last birthday) <b>97</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Reid</b>		14. MOTHER'S MAIDEN NAME <b>Harrietta Gray</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Harriette Hinrichs - 138 Regester Ave. #12</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Fick</b> M.D.		ADDRESS (Street, city or town, state) <b>2 W. University Pkwy</b> DATE SIGNED <b>6-11-59</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>6/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Fickner &amp; Sons - Balto</b>		ADDRESS <b>17 Md</b>	
24a. REC'D BY REGISTRAR <b>DATE 6/12/59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 11, 12 Film 6244 7-14-59 et  
6547  
CERTIFICATE OF DEATH

06537

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, rural.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ARMACOST NURSING HOME</b>		d. STREET ADDRESS <b>GREENWAY APTS.</b>	
3. NAME OF DECEASED (Type or print) First <b>Elsie B.</b> Middle <b>Stewart</b> Last <b>Stewart</b>		4. DATE OF DEATH Month <b>6</b> Day <b>27</b> Year <b>59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-9-1883</b>
9. AGE (In years lost birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Berkeley Co., W. Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SIEBERT BOAK.</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE DAVIS.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>7</b>	
17. INFORMANT <b>ABOVE NURSING HOME.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1955</b> to <b>June 27, 1959</b> , that I last saw the deceased alive on <b>June 27, 1959</b> , and that death occurred at <b>2:55 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>FM Dugan</b>		ADDRESS (Street, city or town, state) <b>15 E. Biddle St Baltimore 2</b>	
PHYSICIAN'S NAME (Type) <b>FM DUGAN MD</b>		DATE SIGNED <b>6/29/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	22b. DATE THEREOF <b>6/27/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GREENHILL</b>	22d. LOCATION (City, town, or county) (State) <b>MARTINSBURG W. VA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickman &amp; Sons</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 29 '59</b>	
ADDRESS <b>North &amp; Pa. Aves. Balt. 17. MD</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	

MEDICAL CERTIFICATION

# CERTIFICATE OF DEATH

BRITISH STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18

Name of Deceased		Age		Sex		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Medical Officer	
John Smith		45		Male		1880		Birmingham		Birmingham		Heart Disease		1925		10:00 AM		Home		J. Smith		Dr. Jones	
Occupation		Married		Single		Widowed		Divorced		Other		Duration of Illness		Period of Incubation		Season of Year		Weather		State of Mind		State of Body	
Clerk		Yes		No		No		No		No		3 Weeks		None		Summer		Fine		Normal		Normal	
Previous Illnesses		Previous Operations		Previous Accidents		Previous Injuries		Previous Fractures		Previous Dislocations		Previous Burns		Previous Scalds		Previous Poisoning		Previous Intoxication		Previous Convulsions		Previous Epilepsy	
None		None		None		None		None		None		None		None		None		None		None		None	
Manner of Death		Place of Burial		Date of Burial		Time of Burial		Place of Interment		Date of Interment		Time of Interment		Place of Cremation		Date of Cremation		Time of Cremation		Place of Disposal		Date of Disposal	
Natural		Birmingham		1925		10:00 AM		Birmingham		1925		10:00 AM		Birmingham		1925		10:00 AM		Birmingham		1925	
Signature of Registrar		Signature of Medical Officer		Signature of Coroner		Signature of Police Officer		Signature of Health Officer		Signature of Social Worker		Signature of Nurse		Signature of Doctor		Signature of Pharmacist		Signature of Dentist		Signature of Optician		Signature of Other	
J. Smith		Dr. Jones		Mr. Brown		Mr. Green		Mr. White		Mr. Black		Mr. Grey		Mr. Blue		Mr. Yellow		Mr. Purple		Mr. Pink		Mr. Brown	

6548

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>108 Church Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Sophia H. McHENRY STEWART</i>		4. DATE OF DEATH <i>June 30 1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 13 1868</i>
9. AGE (In years last birthday) <i>90</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>London England</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Howard McHenry</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Nicholas Cary</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>C. Morton Stewart</i>		Address <i>Eccleston Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral accident</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>myocardial thrombosis, aneurysm fibrosed</i> (c) <i>arteriosclerotic heart disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i> <i>6 weeks</i> <i>25 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 19 37</i> to <i>June 30 19 59</i> , that I last saw the deceased alive on <i>June 30 19 59</i> , and that death occurred at <i>5 P. M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1725 Rockledge Rd. Pikesville Md.</i> DATE SIGNED <i>md.</i>			
ACTUAL SIGNATURE <i>Palmer P. Williams</i> M.D.		PHYSICIAN'S NAME (Type) <i>md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 2 / 59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Thomas</i>		22d. LOCATION (City, town, or county) (State) <i>Garrison Forest Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Jenkins</i>		ADDRESS <i>Ans C 4905 York Rd</i>	
24a. REC'D BY REGISTRAR <i>JUL 2 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur A. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1918

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

BALTIMORE

DECEMBER 1918

W. H. HARRIS

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Time of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Jury

Signature of Witnesses

Signature of Family

Signature of Friends

Signature of Neighbors

Signature of Clergy

Signature of Minister

Signature of Pastor

Signature of Bishop

Signature of Archbishop

Signature of Pope

Signature of Emperor

Signature of King

Signature of Queen

Signature of Prince

Signature of Princess

Signature of Duke

Signature of Duchess

6549

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b> c. LENGTH OF STAY IN 1b <b>3 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1208 Hilldale Ave</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b> d. STREET ADDRESS <b>1208 Hilldale Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>J.</b> Last <b>stickler</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1889</b>
9. AGE (In years last birthday) <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Hoyt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT <b>Andrew C. stickler</b>		Address <b>1208 Hilldale Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Hypertensive Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2.5</b> <b>1070.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb</b> , 19 <b>57</b> , to <b>June 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 30</b> , 19 <b>59</b> , and that death occurred at <b>1208 Hilldale Ave</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>David Schneider</b> M.D. <b>1101 N. Milton Ave, Baltimore-13-Md.</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>DAVID SCHNEIDER</b> <b>1101 N. MILTON AVE BALTIMORE-13-Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 3, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip E. Gvach</b> ADDRESS <b>1211 Chesaco Ave. Balto. 6, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kuntz</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE ATTORNEY GENERAL

1942

11

6550

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>6 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		e. STREET ADDRESS <b>424 N. BROADWAY</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM M SULLIVAN</b>		4. DATE OF DEATH Month Day Year <b>JUNE 30 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-1-1868</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RAILROAD Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES WESTLEY SULLIVAN</b>		14. MOTHER'S MAIDEN NAME <b>LAURA KAUEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank L. Smith Jr.</b>		Address <b>Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11-20</b> , 19 <b>53</b> to <b>6-30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6-30</b> , 19 <b>59</b> , and that death occurred at <b>10:45 PM</b> , from the causes and on the date stated above. <b>Valter T. Kues</b> ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b> DATE SIGNED <b>6/30/59</b>			
ACTUAL SIGNATURE		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 3, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc. 1217 St. Paul St.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Colman S. Krause</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>MALE</b>		3. AGE <b>65</b>	
4. DATE OF DEATH <b>1940</b>		5. TIME OF DEATH <b>10:00 AM</b>		6. PLACE OF DEATH <b>HOME</b>	
7. CAUSE OF DEATH <b>HEART DISEASE</b>		8. MANNER OF DEATH <b>NATURAL</b>		9. PLACE OF BIRTH <b>NEW YORK</b>	
10. OCCUPATION <b>CLERK</b>		11. MARITAL STATUS <b>MARRIED</b>		12. EDUCATION <b>HIGH SCHOOL</b>	
13. PREVIOUS ILLNESS <b>NO</b>		14. PRESENT ILLNESS <b>NO</b>		15. MEDICAL HISTORY <b>NO</b>	
16. PHYSICIAN'S SIGNATURE <b>[Signature]</b>		17. COUNTY HEALTH OFFICER'S SIGNATURE <b>[Signature]</b>		18. CITY HEALTH OFFICER'S SIGNATURE <b>[Signature]</b>	
19. COUNTY OF DEATH <b>BALTIMORE</b>		20. CITY OF DEATH <b>BALTIMORE</b>		21. STATE OF DEATH <b>MARYLAND</b>	
22. DATE OF BIRTH <b>1900</b>		23. TIME OF BIRTH <b>10:00 AM</b>		24. PLACE OF BIRTH <b>NEW YORK</b>	
25. CAUSE OF BIRTH <b>NATURAL</b>		26. MANNER OF BIRTH <b>NATURAL</b>		27. PLACE OF BIRTH <b>NEW YORK</b>	
28. OCCUPATION <b>CLERK</b>		29. MARITAL STATUS <b>MARRIED</b>		30. EDUCATION <b>HIGH SCHOOL</b>	
31. PREVIOUS ILLNESS <b>NO</b>		32. PRESENT ILLNESS <b>NO</b>		33. MEDICAL HISTORY <b>NO</b>	
34. PHYSICIAN'S SIGNATURE <b>[Signature]</b>		35. COUNTY HEALTH OFFICER'S SIGNATURE <b>[Signature]</b>		36. CITY HEALTH OFFICER'S SIGNATURE <b>[Signature]</b>	
37. COUNTY OF BIRTH <b>BALTIMORE</b>		38. CITY OF BIRTH <b>BALTIMORE</b>		39. STATE OF BIRTH <b>MARYLAND</b>	
40. DATE OF DEATH <b>1940</b>		41. TIME OF DEATH <b>10:00 AM</b>		42. PLACE OF DEATH <b>HOME</b>	
43. CAUSE OF DEATH <b>HEART DISEASE</b>		44. MANNER OF DEATH <b>NATURAL</b>		45. PLACE OF BIRTH <b>NEW YORK</b>	
46. OCCUPATION <b>CLERK</b>		47. MARITAL STATUS <b>MARRIED</b>		48. EDUCATION <b>HIGH SCHOOL</b>	
49. PREVIOUS ILLNESS <b>NO</b>		50. PRESENT ILLNESS <b>NO</b>		51. MEDICAL HISTORY <b>NO</b>	
52. PHYSICIAN'S SIGNATURE <b>[Signature]</b>		53. COUNTY HEALTH OFFICER'S SIGNATURE <b>[Signature]</b>		54. CITY HEALTH OFFICER'S SIGNATURE <b>[Signature]</b>	
55. COUNTY OF DEATH <b>BALTIMORE</b>		56. CITY OF DEATH <b>BALTIMORE</b>		57. STATE OF DEATH <b>MARYLAND</b>	

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness, or by the coroner if the death was sudden and unexpected, or by the health officer if the death was due to natural causes and the body was found in a public place.

2. The cause of death should be stated in as few words as possible, but in such a way as to give a clear and concise statement of the facts.

3. The manner of death should be stated as natural, accidental, or suicidal.

4. The place of death should be stated as home, hospital, or other place.

5. The date and time of death should be stated in full.

6. The name of the deceased should be stated in full, and the sex and age should be stated.

7. The occupation, marital status, and education of the deceased should be stated.

8. The previous illness, present illness, and medical history of the deceased should be stated.

9. The signature of the physician or other qualified person, the health officer, and the coroner should be stated.

10. The county, city, and state of death and birth should be stated.

6551

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MIDDLE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AMY</b> Middle <b>MARIE</b> Last <b>SWETZ</b>				4. DATE OF DEATH Month <b>6</b> Day <b>21</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/3/57</b>	9. AGE (In years last birthday) <b>2</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Anthony Swetz</b>				14. MOTHER'S MAIDEN NAME <b>Helen R. Sczepaucha</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. -----		INFORMANT <b>Rosewood Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrocephalus, marked</b> <b>344X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>2:45 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6/22/59</b>							
ACTUAL SIGNATURE <b>P. W. Rieckert</b>		M.D. <b>Palladium</b>					
PHYSICIAN'S NAME (Type) <b>P. W. Rieckert</b>		<b>4607 Mainfield Ave, City #14</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/23/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>		22d. LOCATION (City, town, or county) (State) <b>P.A. Co. Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. S. Falkowski</b>		ADDRESS <b>2007 Eastern Ave</b>		24a. REC'D BY REGISTRAR <b>JUN 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

1

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING

1921

1

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING

1921

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WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06542

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Howard</b>		c. LENGTH OF STAY IN 1b <b>?</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Todd Ave. &amp; Bayside Ft. Howard</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b>	
f. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Todd Ave. &amp; Bayside Ft. Howard</b>		g. STREET ADDRESS <b>1714 Pinewood Road</b>	
h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John Thomas Szelistowski Jr.</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 22, 1925</b>	
9. AGE (In years last birthday) <b>33</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John T. Szelistowski Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Irma Oberhansli</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>219-107535</b>	
17. INFORMANT <b>Mrs. Medarda Szelistowski</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> <b>971.8</b> DUE TO <b>CO Poisoning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CO Poisoning</b> (c) <b>CO Poisoning</b>		INTERVAL BETWEEN ONSET AND DEATH <b>50 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Jack C. Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Jack C. Collins</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 11, 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Road Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. 22, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



6553

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Chester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KINGSVILLE</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RT# 1</u>				d. STREET ADDRESS <u>511 Lincoln Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>THERESA</u> Middle <u>E.</u> Last <u>TALUCCI</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> , Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/28/1908</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cutler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Domenico CATALDI</u>				14. MOTHER'S MAIDEN NAME <u>ANNUNZIATA PERRELI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>164-26-6978</u>		17. INFORMANT <u>Domenico Talucci</u>		Address <u>Downtown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aorta with massive hemothorax</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto-auto collision</u>					
20c. TIME OF INJURY Hour <u>8:30</u> p.m. Month, Day, Year <u>6/19/1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road</u>		20f. (City or town) (County) (State) <u>Baltimore Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Charles S. Petty</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles S. Petty, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>6/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph R.C.</u>		22d. LOCATION (City, town, or county) (State) <u>Downtown R</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Belton</u>				ADDRESS <u>Downtown</u>			
24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			
DATE <u>JUL 13 1959</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13708

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNABRE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. EDUCATION [Illegible]	
9. PRESENT RESIDENCE [Illegible]		10. DATE OF DEATH [Illegible]	
11. CAUSE OF DEATH [Illegible]		12. MANNER OF DEATH [Illegible]	
13. SIGNATURE OF EXAMINER [Illegible]		14. SIGNATURE OF WITNESS [Illegible]	
15. SIGNATURE OF DECEASED [Illegible]		16. SIGNATURE OF NEXT OF KIN [Illegible]	
17. SIGNATURE OF CLERK [Illegible]		18. SIGNATURE OF JURY [Illegible]	
19. SIGNATURE OF JURY [Illegible]		20. SIGNATURE OF JURY [Illegible]	
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87. SIGNATURE OF JURY [Illegible]		88. SIGNATURE OF JURY [Illegible]	
89. SIGNATURE OF JURY [Illegible]		90. SIGNATURE OF JURY [Illegible]	
91. SIGNATURE OF JURY [Illegible]		92. SIGNATURE OF JURY [Illegible]	
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97. SIGNATURE OF JURY [Illegible]		98. SIGNATURE OF JURY [Illegible]	
99. SIGNATURE OF JURY [Illegible]		100. SIGNATURE OF JURY [Illegible]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNABRE 10

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNABRE 10

# 1 6554 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6554 CERTIFICATE OF DEATH

06543

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PIKESVILLE</b> c. LENGTH OF STAY IN 1b <b>35 YRS.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>111 BRIGHTSIDE AVE.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X PIKESVILLE</b> d. STREET ADDRESS <b>111 BRIGHTSIDE AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>AMELIA</b> Middle <b>TAPSFIELD</b> Last <b>TAPSFIELD</b>		4. DATE OF DEATH Month <b>6</b> Day <b>-14-</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29, 1877</b> 9. AGE (In years last birthday) yrs. <b>81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES Siebert</b>		14. MOTHER'S MAIDEN NAME <b>SCHMIDT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Charles S. Ransone, 3601 Sylvan Drive.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>Generalized Art. Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>3 yrs.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 1, 1939</b> to <b>June 1, 1959</b> , that I last saw the deceased alive on <b>Mar. 30, 1959</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James A. Miller M.D.</b>		ADDRESS (Street, city or town, state) <b>1331 Reisterstown Rd. Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>James A. Miller M.D.</b>		DATE SIGNED <b>6/16/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-17-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews</b>		22d. LOCATION (City, town, or county) (State) <b>O'Donnell St. Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b>		ADDRESS <b>Pikesville, Md.</b>	
24a. REGISTRY-REGISTRAR <b>JUN 23 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Thomas</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH BALTIMORE 10 CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Date of birth

4. Place of birth

5. Date of death

6. Time of death

7. Place of death

8. Cause of death

9. Nature of disease

10. Duration of disease

11. Name of physician

12. Name of attending physician

13. Name of coroner

14. Name of registrar

15. Name of informant

16. Name of informant

17. Name of informant

18. Name of informant

19. Name of informant

20. Name of informant

21. Name of informant

22. Name of informant

23. Name of informant

24. Name of informant

25. Name of informant

26. Name of informant

27. Name of informant

28. Name of informant

29. Name of informant

30. Name of informant

31. Name of informant

32. Name of informant

33. Name of informant

34. Name of informant

35. Name of informant

36. Name of informant

37. Name of informant

38. Name of informant

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6555

CERTIFICATE OF DEATH

06544

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>812 Melford Mill Road</i>		d. STREET ADDRESS <i>812 Melford Mill Rd</i>	
3. NAME OF DECEASED (Type or print) First <i>Rose</i> Middle <i>Tarses</i> Last <i>Tarses</i>		4. DATE OF DEATH Month <i>6</i> - Day <i>22</i> - Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Russia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Morris Homkowsky</i>	
14. MOTHER'S MAIDEN NAME <i>Minnie</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>INFORMANT</i>		Address <i>Beverly Exler - Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive heart failure</i> DUE TO (b) <i>Hypertensive arteriosclerotic</i> DUE TO (c) <i>Cardiovascular disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i> <i>10 yrs?</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 2</i> 19 <i>56</i> to <i>June 22</i> 19 <i>59</i> , that I last saw the deceased alive on <i>June 22</i> 19 <i>59</i> , and that death occurred at <i>3:54 PM</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph C. Thatcher</i>		ADDRESS (Street, city or town, state) <i>4004 Liberty St. Balto Md</i>	
PHYSICIAN'S NAME (Type) <i>JOSEPH C. THATCHER</i>		DATE SIGNED <i>6/24/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>6-23-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Beth Isaac</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc</i>		ADDRESS <i>2100 Eutaw Pl</i>	
24a. REC'D BY REGISTRAR <i>JUN 23 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

10883

STATE OF NEW YORK

0250

OFFICE OF THE  
CLERK OF THE  
SUPREME COURT

STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1900

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "and" and "the" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6403

## CERTIFICATE OF DEATH

06545

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARBUTUS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 ARBUTUS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LOCUST AVE.</u>		d. STREET ADDRESS <u>1 LOCUST AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Isabelle</u> <u>Teipe</u>		4. DATE OF DEATH Month Day Year <u>June 27</u> <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 23 1863</u>
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ANTHONY Gocking</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN HENLET</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MISS. CLARA S. TEIPE</u>		Address <u>LOCUST AVE. ARBUTUS, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cholera</u> DUE TO (c) <u>General arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>14 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 27</u> , 19 <u>59</u> , to <u>June 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 26</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1014 Francis Ave - Baltimore</u>			
ACTUAL SIGNATURE <u>FREDERICK V. BEITLER</u>		M.D. <u>1014 Francis Ave - Baltimore</u>	
PHYSICIAN'S NAME (Type) <u>FREDERICK V. BEITLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 1, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Truman Schwaab</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	
24a. REC'D BY REGISTRAR <u>DATE JUL 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

1. NAME OF DECEASED		2. DATE OF DEATH		3. PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	

4. SEX		5. AGE		6. RACE	
MALE		39		WHITE	

7. BIRTH DATE		8. BIRTH PLACE		9. MARRIAGE DATE	
JANUARY 5, 1929		MEMPHIS, TENNESSEE		MAY 1, 1955	

10. OCCUPATION		11. EDUCATION		12. RELIGION	
CONGRESSMAN		HIGH SCHOOL		METHODIST	

13. CAUSE OF DEATH		14. MANNER OF DEATH		15. PLACE OF DEATH	
HEART DISEASE		SUICIDE		MEMPHIS, TENNESSEE	

16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESS		21. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

22. SIGNATURE OF DECEASED		23. SIGNATURE OF WITNESS		24. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESS		27. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

28. SIGNATURE OF DECEASED		29. SIGNATURE OF WITNESS		30. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESS		33. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

34. SIGNATURE OF DECEASED		35. SIGNATURE OF WITNESS		36. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

37. SIGNATURE OF DECEASED		38. SIGNATURE OF WITNESS		39. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

40. SIGNATURE OF DECEASED		41. SIGNATURE OF WITNESS		42. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

43. SIGNATURE OF DECEASED		44. SIGNATURE OF WITNESS		45. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESS		48. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

49. SIGNATURE OF DECEASED		50. SIGNATURE OF WITNESS		51. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

52. SIGNATURE OF DECEASED		53. SIGNATURE OF WITNESS		54. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

55. SIGNATURE OF DECEASED		56. SIGNATURE OF WITNESS		57. SIGNATURE OF DOCTOR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

6556

## CERTIFICATE OF DEATH

06546

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>JONES' CREEK</b>		c. LENGTH OF STAY IN 1b <b>34 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2424 WYTHE AVE.</b>		d. STREET ADDRESS <b>2424 WYTHE AVE</b>	
3. NAME OF DECEASED (Type or print) <b>DANIEL H. TEMPLE</b>		4. DATE OF DEATH <b>6/4/59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 17, 1969</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TANK CASTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIP CONSTR.</b>	
11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>SAMUEL TEMPLE</b>		14. MOTHER'S MAIDEN NAME <b>MARC. ENGLAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-09-2485</b>	
17. INFORMANT <b>MINNIE M. TEMPLE - SAME</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>56</b> , to <b>June 4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug. 3</b> , 19 <b>59</b> , and that death occurred at <b>9:00 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James T. Means</b>		ADDRESS (Street, city or town, state) <b>5200 St. Balto, Md</b>	
PHYSICIAN'S NAME (Type) <b>James T. Means</b>		DATE SIGNED <b>6-8-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/8/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GARDENS FAITH</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. CO., MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur R. Bradley, Dundalk, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 10 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Means</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAR 1918  
DEPT OF HEALTH  
Baltimore  
1

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED JAMES W. WILSON		2. SEX Male	
3. AGE 45		4. DATE OF BIRTH Jan 15 1873	
5. PLACE OF BIRTH Baltimore, Md		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. CAUSE OF DEATH Heart Disease	
9. PLACE OF DEATH Home		10. TIME OF DEATH 10:30 AM	
11. SIGNATURE OF PHYSICIAN J. H. Smith		12. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones	
13. NAME OF CLERGYMAN Rev. J. H. Smith		14. NAME OF FUNERAL HOME J. H. Smith	
15. NAME OF BURIAL PLACE St. John's Church		16. NAME OF CEMETERY St. John's Cemetery	
17. NAME OF COUNTY Baltimore		18. NAME OF STATE Maryland	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06547

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex-317 Worton Rd.</u>		c. LENGTH OF STAY IN 1b <u>54</u> <u>Essex</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex</u>		d. STREET ADDRESS <u>317 Worton Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ernie Tennant</u> First <u>(Tennant)</u> Middle Last				4. DATE OF DEATH <u>June 24, 1959</u> Month <u>19</u> Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>May 20, 1891</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired maintenance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Board of Education</u>		11. BIRTHPLACE (State or foreign country) <u>Fairview, W. Virginia</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>David Tennant</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>282-09-0388</u>		17. INFORMANT <u>Mrs. Wanda Standifer, 317 Worton Rd. Essex</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis of Heart</u> DUE TO <u>5 years</u> (c) <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>80 mm</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Jack E Collins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack E Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>June 28, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bassnetville, W. Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickenner + sons Baltimore</u>				24a. REC'D BY REGISTRAR <u>June 25 59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. French</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.



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TO BE FILLED IN BY THE INSTITUTIONAL OFFICER IN CHARGE OF THE INSTITUTION IN WHICH THE PATIENT IS DETAINED. TO BE FILLED IN BY THE INSTITUTIONAL OFFICER IN CHARGE OF THE INSTITUTION IN WHICH THE PATIENT IS DETAINED. TO BE FILLED IN BY THE INSTITUTIONAL OFFICER IN CHARGE OF THE INSTITUTION IN WHICH THE PATIENT IS DETAINED.

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6558

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> c. LENGTH OF STAY IN 1b <b>3200 Offutt Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> d. STREET ADDRESS <b>3200 Offutt Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FRANK L. THOMAS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1975</b> 9. AGE (In years last birthday) <b>83</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Co., Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elias Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Catherine L. McKnew</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-34-2899A</b>	
17. INFORMANT <b>Mrs. Anna L. Thomas-3200 Offutt Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Acute Pulmonary edema.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/8</b> , 19 <b>59</b> , to <b>6/8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/8</b> , 19 <b>59</b> , and that death occurred at <b>11 30</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Morton J. Ellin</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Morton J. Ellin, M.D.</b>		<b>7039 Liberty Road - Baltimore 7, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/11/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>		ADDRESS <b>4600 Liberty Hghts. Ave.</b>	
24a. REC'D BY REGISTRAR <b>JUN 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6559

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>50 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>L.</b> Last <b>THOMAS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 1, 1919</b>
9. AGE (In years last birthday) <b>39</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ice Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John A. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Bubler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>VW II</b>		16. SOCIAL SECURITY NO. <b>212-16-2828</b>	
17. INFORMANT <b>Clin. Rec. Vet. Adm. Hospital, Fort Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LAENNEC'S CIRRHOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Polynuritis, lower extremities - 13 yrs. 2. Tuberculosis, Pulmonary, Moderately advanced, inactive 8 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 9, 1959</b> , 19____, to <b>June 28</b> , 19____, and that death occurred at <b>2:05A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6/28/59</b>			
ACTUAL SIGNATURE <i>Moses Lichtig</i>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>MOSES LICHTIG, M.D.</b>		<b>VAH, FORT HOWARD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-1-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips, 1808-10 N. Monroe St.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>	
ADDRESS <b>Baltimore 17, Md.</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur A. Frank</i>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

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DEPARTMENT OF HEALTH

BALTIMORE, MD.

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BALTIMORE, MD.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06550

6560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>151 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KORNMANN</b> Middle <b>P.</b> Last <b>TOMLINSON</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1897</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Clerk</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William L. Tomlinson</b>	
14. MOTHER'S MAIDEN NAME <b>Katie Aylman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>	
16. SOCIAL SECURITY NO. <b>218-09-8738</b>		17. INFORMANT <b>Clinical Rec. VA Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CANCER OF LUNG</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ESS. VASC. HYPERTENSION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 14, 19 59, to June 14, 19 59</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA Hospital, Ft. Howard, Md. 6/14/59</b>			
ACTUAL SIGNATURE <b>Hiram B. Curry</b> M.D.		PHYSICIAN'S NAME (Type) <b>HIRAM B. CURRY, M.D.</b> VA Hospital, Ft. Howard, Md. 6/14/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-17-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>			

WM. COOK-BLIGHT, INC. 6009 HARFORD RD BALTO MD

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6561 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06551

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>Baltimore</b> 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Five Farms Golf Course</b>		d. STREET ADDRESS <b>5307 St. Albans Way</b>	
3. NAME OF DECEASED (Type or print) <b>R. KENT TONGUE, Jr.</b>		4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 4, 1918</b>
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Orthodontist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Raymond K. Tongue</b>		14. MOTHER'S MAIDEN NAME <b>Lena N. Tongue</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes World War II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Barbara E. Tongue</b>		Address <b>5307 St. Albans Way</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>Sudden</b> (c) <b>giving rise to the underlying cause lost.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/11/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/13/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiekner &amp; Sons - Balto.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Jones</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06553  
6563 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Back River Neck(Rural)</b>		c. LENGTH OF STAY IN lb <b>40 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ERNEST W. VANDERMAST, SR</b>		4. DATE OF DEATH Month <b>6</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/22/1897</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REAL ESTATE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ARNOLD S VANDERMAST</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH HERR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-10-1256</b>	
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Jack C Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JACK C COLLINS</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6-5-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/9/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE</b>		22d. LOCATION (City, town, or county) (State) <b>DORSET, md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Burke Bradley, Dorset</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

5th. Page 4

TO HOSPITAL OR

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G244 7/8/59 cap

06552

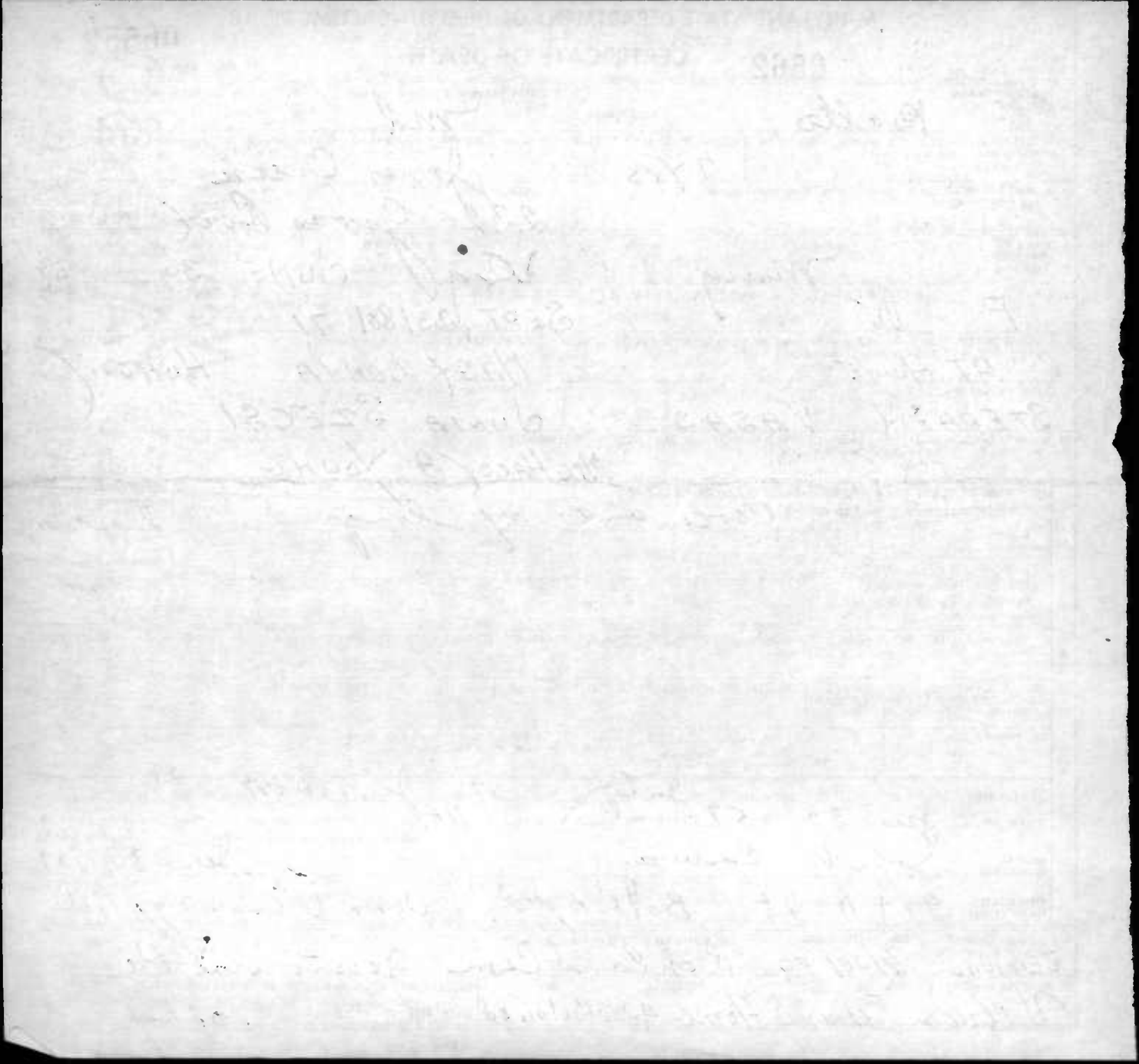
6562

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>				c. LENGTH OF STAY IN 1b <u>7 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Wig</u> Last <u>Wig</u>				DATE OF DEATH <u>JUNE 30 19 59</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 23 1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>59</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>59</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>HUNGARY</u>				12. CITIZEN OF WHAT COUNTRY? <u>HUNGARY</u>			
13. FATHER'S NAME <u>STEPHEN VASAS</u>				14. MOTHER'S MAIDEN NAME <u>JULIA SZECSEI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mrs HARRY A YOUNG</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> DUE TO <u>Carcinoma of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>July 1, 19 57</u> to <u>June 30, 19 59</u> , that I last saw the deceased alive on <u>June 30, 19 59</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John V. Conway</u> M.D.				DATE SIGNED <u>June 30, 19 59</u>			
PHYSICIAN'S NAME (Type) <u>914 D St., Balt Md</u>				John V Conway, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVED</u>				22b. DATE THEREOF <u>6/30/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Richland Cem</u>				22d. LOCATION (City, town, or county) <u>Georgetown Pa</u> (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home</u> ADDRESS <u>4210 Belair Rd</u>				24a. REC'D BY REGISTRAR <u>John V Conway</u> DATE <u>JUL 6 '59</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06554

6564

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY in 1b <b>lyrlmthldys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>			d. STREET ADDRESS <b>402 Hazlett Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Garnett</b> Middle <b>Haucke</b> Last <b>Vines</b>			4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 59</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1880</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
13. FATHER'S NAME <b>Albert Huacke</b>			14. MOTHER'S MAIDEN NAME <b>Leona Stuart</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		(County) (State)			
21. I certify that I attended the deceased from <b>May 22</b> , 19 <b>58</b> , to <b>June 26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 26</b> , 19 <b>59</b> , and that death occurred at <b>2:05 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-26-59</b>					
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M.D. <b>SPRING GROVE STATE HOSPITAL 6-26-59</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/29/59</b>		22b. DATE THEREOF <b>6/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Maysville</b>	
22d. LOCATION (City, town, or county) <b>Maysville Ky.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>William J. Tickner &amp; Sons</b>			ADDRESS <b>N. &amp; Pa. Balto 17 Md</b>		
24a. REC'D BY REGISTRAR <b>JUN 29 '59</b>			DATE		
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					



## CERTIFICATE OF DEATH

06555

Reg. Dist. No.

6404

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN lb <u>20yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1343 Poplar Ave</u>		1 d. STREET ADDRESS <u>1343 Poplar Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Homer L. Waite</u>		4. DATE OF DEATH Month Day Year <u>June 15 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15 1894</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Waite</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Sanderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>015-03-748</u>	
17. INFORMANT Address <u>Stella L. Waite 1343 Poplar Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>7</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duodenal Ulcer - hemorrhage</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>8-21</u> 19 <u>59</u> , to <u>6-15</u> 19 <u>59</u> , that I last saw the deceased alive on <u>June 15</u> 19 <u>59</u> , and that death occurred at <u>4:10 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl Pass</u> M.D.		ADDRESS (Street, city or town, state) <u>4501 Wickens Ave. Pk 29</u> DATE SIGNED <u>6-15-59</u>	
PHYSICIAN'S NAME (Type) <u>I. EARL PASS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>North Hatfield Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>North Hatfield Massachusetts</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amelia Inc. 1328 Sulphur Spring Rd</u> ADDRESS _____		24a. REC'D BY REGISTRAR <u>JUN 16 '59</u> DATE _____	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thane</u>

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06556

## 6565 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN TB <b>5 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>R.</b> Last <b>WALTMAN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1899</b>
9. AGE (In years last birthday) yrs. <b>60</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Muncy, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Waltman</b>		14. MOTHER'S MAIDEN NAME <b>Mary Reichelderfer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>181-09-9031</b>	
17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INFARCTION OF MYOCARDIUM</b> <b>420.0</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>UNKNOWN</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 14, 1959</b> to <b>June 19, 1959</b> , and that death occurred at <b>6:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W. Crawford</i>		DATE SIGNED <b>6/19/59</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		<b>VAH, FORT HOWARD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-22-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Blight, Inc.</i>		ADDRESS <b>6009 Harford Rd.</b>	
24a. REC'D BY REGISTRAR <b>JUN 22 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11223

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

## CERTIFICATE OF DEATH

Last Name

First Name

Middle Name

Sex

Age

Date of Birth

Place of Birth

Cause of Death

Date of Death

Time of Death

Place of Death

Signature

Date

Occupation

Education

Marital Status

Religion

Previous Illnesses

Hobbies

Family History

Social History

Medical History

Dental History

Surgical History

Anesthesia History

Allergies

Medications

Vaccinations

Transfusions

Other Medical Information

Other Information

Remarks

Signature

Date

Place

Signature

Date

Occupation

Education

Marital Status

Religion

Previous Illnesses

Hobbies

Family History

Social History

Medical History

Dental History

Surgical History

Anesthesia History

Allergies

Medications

Vaccinations

Transfusions

Other Medical Information

Other Information

Remarks

Signature

Date

Place

Signature

Date

Occupation

Education

Marital Status

Religion

Previous Illnesses

Hobbies

Family History

Social History

Medical History

Dental History

Surgical History

Anesthesia History

Allergies

Medications

Vaccinations

Transfusions

Other Medical Information

Other Information

Remarks

Signature

Date

Place

Signature

Date

Occupation

Education

Marital Status

Religion

Previous Illnesses

Hobbies

Family History

Social History

Medical History

Dental History

Surgical History

Anesthesia History

Allergies

Medications

Vaccinations

Transfusions

Other Medical Information

Other Information

Remarks

Signature

Date

Place

Signature

Date

Occupation

Education

Marital Status

Religion

Previous Illnesses

Hobbies

Family History

Social History

Medical History

Dental History

Surgical History

Anesthesia History

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06557

## 6566 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>68 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JESSE F. WATTERS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1932</b>
9. AGE (In years last birthday) <b>27</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Body &amp; Fender Repair</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto. Garage</b>	
11. BIRTHPLACE (State or foreign country) <b>Edgewood, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul H. Watters</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Hoerr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Korean</b>		16. SOCIAL SECURITY NO. <b>216-28-1622</b>	
17. INFORMANT <b>Clinical Rec. VA Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.2 INTRA-ABDOMINAL CARCINOMATOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 13</b> , 19 <b>59</b> , to <b>June 20</b> , 19 <b>59</b> , and that death occurred at <b>8:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Irving H. Shonberg</b>		DATE SIGNED <b>6/20/59</b>	
PHYSICIAN'S NAME (Type) <b>IRVING H. SHONBERG</b>		ADDRESS (Street, city or town, state) <b>VA Hospital, Ft. Howard, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 23, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. Brown Jr.</b>		24a. REC'D BY REGISTRAR <b>JUN 23 '59</b>	
ADDRESS <b>Abingdon Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MC COMAS FUNERAL HOME, ABINGDON, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File No.

DATE OF DEATH

Place of Birth

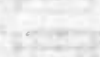
Age

Sex

3

Color

Occupation



Signature of Registrar

Date



## 6567 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b> c. LENGTH OF STAY IN 1b <b>11 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> d. STREET ADDRESS <b>RFD 6</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Also Known as) First <b>THEODORE</b> Middle <b>A.</b> Last <b>JEMMERSON</b> <b>RONALD R. WEAVER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barbershop</b>	9. AGE (In years last birthday) <b>62</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Scottdale, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Otto Weaver</b>		14. MOTHER'S MAIDEN NAME <b>Margaret MN: Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>219-30-6634</b>	
17. INFORMANT <b>Clinical Records</b>		Address <b>VET. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per part (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>TUBERCULOSIS, PULMONARY, ARRESTED</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>TUBERCULOSIS, PULMONARY, ARRESTED</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>X</del> <b>VA</b> attended the deceased from <b>May 27, 1959</b> , to <b>June 7, 1959</b> , and that death occurred at <b>1:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. W. Schier M.D.</b>		ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>W. W. SCHIER, M.D., Director, Professional Services, VAH, Fort Howard, Md.</b>		DATE SIGNED <b>6/8/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-10-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore</b>	22d. LOCATION (City, town, or county) (State) <b>Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Dabrowski Funeral Home, 1001A Dundalk Ave.</b>		24a. REC'D BY REGISTRAR <b>JUN 9 '59</b>	
ADDRESS <b>Baltimore, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kious</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6568 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>305 THACKERAY AVE</u>				d. STREET ADDRESS <u>1305 THACKERAY AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>PERCIVAL</u> Middle <u>S.</u> Last <u>WHIPPLE</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 25, 1889</u>	9. AGE (In years lost birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REALTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PROP.-RET</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>DORRIS WHIPPLE</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Percival Whipple 305 Thackeray</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>arterio sclerosis</u> (c) <u>arterio sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>10 years</u> <u>10 years</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>August 1930</u> to <u>June 7</u> 19 <u>59</u> , that I last saw the deceased alive on <u>June 6</u> 19 <u>59</u> , and that death occurred at <u>230 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. Lee Fort</u>		M.D. <u>6 Dutton Ave. Balto.</u>		ADDRESS (Street, city or town, state)			DATE SIGNED
PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wheaton Heights Cem.</u>		22d. LOCATION (City, town, or county) <u>Elkridge Md.</u>			(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Forley Funeral Home - Elkridge, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 15 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06560  
6569 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3927 Cecil ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Christine White</u>		4. DATE OF DEATH <u>June 17 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 22 1895</u> 63 yrs.
9. AGE (In years, months, and days) <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months <u>17</u> Days <u>19</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto City</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hebe</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hebe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John H White 57 Cecil ave</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Due to</u> (c) <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 18, 1959</u>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER MD</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial June 20/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co 5nd</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Deifel 5311 Edmondson Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 19 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>S. Kraw</u>			

FOR STATE  
HEALTH DEPT.

STATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Married

Single

Widow

Divorced

Never married

Married

Single

Widow

Divorced

Never married

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18 110300  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
BALTIMORE  
JAN 10 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06561

6405

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>				c. LENGTH OF STAY IN 1b <b>51 Arbutus</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1239 Greystone Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LULA</b> Middle <b>R.</b> Last <b>WHITE</b>				4. DATE OF DEATH Month <b>June 13,</b> Day <b>19</b> Year <b>59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 11, 1890</b>	
9. AGE (In years lost in day) yrs. <b>68</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>George Brown</b>			
14. MOTHER'S MAIDEN NAME <b>Margaret Salmon</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Mrs. Dorothy H. Thomas - 1239 Greystone Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chr. Hypertensive Cardio-Vascular Disease</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>2 ds.</b> <b>10 30'</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <b>3-12, 1950</b> , to <b>6-13, 1959</b> , that I last saw the deceased alive on <b>6-12, 1959</b> , and that death occurred at <b>R. 300 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wilmer K. Callager</b>				ADDRESS (Street, city or town, state) <b>6209 Frederick Ave. Baltimore-28, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Wilmer K. Callager</b>				DATE SIGNED <b>6-15-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Sicker</b>				ADDRESS <b>Sous-Balto</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>							

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
**CERTIFICATE OF DEATH**

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "Jan 15 1920"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF BURIAL [Faint text, possibly "Catholic Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CITY [Faint text, possibly "Baltimore"]		COUNTY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Maryland"]	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the city or county in which the death occurred.

## CERTIFICATE OF DEATH

Reg. Dist. No.

6570

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 Hilton Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LULU N. WILSON</u> First Middle Last		4. DATE OF DEATH <u>6 11 1959</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/176</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilson B. Nichols</u>		14. MOTHER'S MAIDEN NAME <u>Arnold</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Adm Heller Preston</u>	
17. INFORMANT Address <u>Adm Heller Preston</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adeno-carcinoma of Pancreas</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1932</u> to <u>June 11, 1959</u> that I last saw the deceased alive on <u>6-10, 1959</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. H. Fort</u>		ADDRESS (Street, city or town, state) <u>6 Dutton Ave</u>	
PHYSICIAN'S NAME (Type) <u>Wetherbee Fort, Balto. 78-</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Spencer &amp; Son</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JUN 15 59</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

6571

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>600 Columbia Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSS</b> Middle <b>K.</b> Last <b>WIRT</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26, 1894</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Jacob L. Wirt</b>		14. MOTHER'S MAIDEN NAME <b>Emma - (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give year or dates of service) <b>World War I</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Lena B. Wirt - 600 Columbia Rd., Ellicott /</b>		Address City	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY THROMBOSIS</b> DUE TO (c) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 HR.</b> <b>2 HRS.</b> <b>10 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1956</b> to <b>6-14</b> , <b>1959</b> , that I last saw the deceased alive on <b>6-14</b> , <b>1959</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>COLUMBIA RD</b> DATE SIGNED <b>6-15-59</b>	
ACTUAL SIGNATURE <b>P. V. Thorpe</b>	PHYSICIAN'S NAME (Type) <b>PETER V. THORPE MD</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/16/59</b>
22c. NAME OF CEMETERY OR CREMATORY <b>Rolling Green Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>New Cumberland, Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Schenker &amp; Sons - Balt 17 Md</b>	24a. REC'D BY REGISTRAR DATE <b>JUN 15 '59</b>
24b. REGISTRAR'S SIGNATURE <b>Colman S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

and birth

ADULT IN 25

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES M. JONES		35		M		W		C	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
JAN 10 1918		BALTIMORE, MD		HEART DISEASE		NATURAL		LABORER	
DATE OF BIRTH		PLACE OF BIRTH		MOTHER'S NAME		FATHER'S NAME		MARRIAGE DATE	
JAN 10 1883		BALTIMORE, MD		JANE JONES		JOHN JONES		JAN 10 1910	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CLERGYMAN	
JAN 15 1918		BALTIMORE, MD		J. J. JONES		J. J. JONES		J. J. JONES	
DATE OF REGISTRATION		PLACE OF REGISTRATION		NAME OF REGISTRAR		NAME OF CLERK		NAME OF ASSISTANT	
JAN 15 1918		BALTIMORE, MD		J. J. JONES		J. J. JONES		J. J. JONES	

## 6572 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparks,</b>		c. LENGTH OF STAY IN lb <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>York Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Henry Wirtz</b>		4. DATE OF DEATH Month Day Year <b>6-16-59</b> 19 <b>59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-16-1876</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Wirtz</b>		14. MOTHER'S MAIDEN NAME <b>??? Walker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-20-4742</b>	
17. INFORMANT <b>Willis W. Wirtz, Sparks, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio cordia-vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-10</b> , 19 <b>59</b> , to <b>6-16</b> , 19 <b>59</b> that I last saw the deceased alive on <b>6-11</b> , 19 <b>59</b> , and that death occurred at <b>12:30</b> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Herbert Mueller, Jr., M.D.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>York Rd., Parkton, Md.</b>	
PHYSICIAN'S NAME (Type) <b>C. Herbert Mueller, Jr., M.D.</b>		<b>York Rd., Parkton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-19-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Jessops Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Sparks, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6573

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06565

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>503 Fairview Avenue</u>				d. STREET ADDRESS <u>503 Fairview Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Elsa</u> Middle <u>WOLLNER</u> Last <u>WOLLNER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1877</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(ret'd) Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u> ✓	
13. FATHER'S NAME <u>(unknown) Philipson</u>				14. MOTHER'S MAIDEN NAME <u>Unknoen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Thomas J. Neenan, 27 West Cedar Hill Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u>	(County) <u></u>	(State) <u></u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack C Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>JUN 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the medical examiner, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6574

## CERTIFICATE OF DEATH

06566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u>		c. LENGTH OF STAY IN 1b <u>24 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6700 WINDSOR MILL RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PHILIP FIELDS ZIMMERMAN</u>		4. DATE OF DEATH Month Day Year <u>6 17 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 9, 1890</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COMMISSION MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COMMISSION MERCHANT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM E. ZIMMERMAN</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA STEELE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-248952</u>	
17. INFORMANT <u>SISTER - MRS LOLS</u>		Address <u>6704 WINDSOR MILL RD BALTO 7</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIO VASCULAR RENAL DISEASE</u> DUE TO (c) <u>15 YEARS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JANUARY 15, 19 49</u> , to <u>JUNE 17, 19 59</u> , that I last saw the deceased alive on <u>JUNE 16, 19 59</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin L Pierpont</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>2204 LIBERTY RD BALTO 7, MD 6/17/59</u>	
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>June 20 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Clare Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Randallstown, Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William L. Lamotheau</u>		ADDRESS <u>1003 N Baltimore St</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Caroline S. Thomas</u>	

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO SHALL TRANSMIT IT TO THE STATE DEPARTMENT OF HEALTH. IT IS TO BE FURNISHED TO THE FUNERAL HOME AT THE REQUEST OF THE NEXT OF KIN.

# CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN DOE</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>1910</i>		5. PLACE OF BIRTH <i>NEW YORK</i>		6. OCCUPATION <i>DRUGGIST</i>	
7. MARITAL STATUS <i>MARRIED</i>		8. CITY OF RESIDENCE <i>NEW YORK</i>		9. COUNTY OF RESIDENCE <i>NEW YORK</i>		10. STATE OF RESIDENCE <i>NEW YORK</i>		11. DATE OF DEATH <i>1955</i>		12. PLACE OF DEATH <i>HOME</i>	
13. CAUSE OF DEATH <i>HEART DISEASE</i>		14. MANNER OF DEATH <i>NATURAL</i>		15. MEDICAL HISTORY <i>None</i>		16. PRESENT ILLNESS <i>None</i>		17. TIME OF DEATH <i>10:00 AM</i>		18. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
19. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		20. ADDRESS OF NEXT OF KIN <i>123 Main St, New York</i>		21. CITY OF NEXT OF KIN <i>NEW YORK</i>		22. STATE OF NEXT OF KIN <i>NEW YORK</i>		23. DATE OF FILING <i>1955</i>		24. SIGNATURE OF REGISTRAR <i>John Doe</i>	